1. Smartphone apps for asthma medication adherence: systematic review of underlying adherence theories and behaviour change techniques.

Samaresh Mazumdar, Elizabeth Edwards, Anna De Simoni.

Adherence to asthma medication is known to be poor, leading to higher disease mortality. Theoretical frameworks can help illuminate why people fail to take medication as prescribed, and help inform the development of interventions to improve medication adherence. The use of smartphone applications (apps) has been advocated as a future delivery method of improving medication adherence.

The aim of this study is to assess the proportion of existing smartphone apps that use constructs from the Perceptions and Practicalities Approach framework (PAPA), behaviour change techniques (BCTs) and gamification to improve asthma medication adherence.

A systematic review of the content of all English language apps that aim to support asthma medication adherence available on the official Apple and Android app stores, and assess their use of:

- Constructs from the PAPA framework
- BCTs
- Gamification

All paid and free apps are included, using search terms asthma, inhaler, asthma/inhaler reminder, asthma/inhaler alarm and peak flow. Sixty-seven apps are included in the analysis. Preliminary data suggests that asthma adherence apps focus primarily on practical (e.g. reminders) rather than perceptual (e.g. educational) barriers.

The review is ongoing and detailed analyses will be presented at the conference. The number of BCTs will be compared in (i) apps that address perceptual barriers and practical barriers versus those that do not and (ii) in gamified versus non-gamified apps. The number of BCTs will be compared to user ratings and price. Statistical significance of the association between the number of BCTs with user ratings and price will be determined by linear regression or Spearman’s Rank Correlation Coefficient as appropriate.

Apps that support asthma medication adherence are currently fairly basic in content. Future app development should go beyond practical barriers to target perceptual barriers, perhaps using a variety of different BCTs.
2. Effects of pedometer-based walking interventions after 3-4 years follow-up:- results from two randomised controlled trials in UK primary care (Plenary session)

Tess Harris, Sally Kerry, Derek Cook

Effects of pedometer-based walking interventions after 3-4 years follow-up:- results from two randomised controlled trials in UK primary care

Physical inactivity is an important cause of non-communicable diseases. Interventions can increase short-term physical activity (PA), but health benefits require maintenance. Few interventions have evaluated PA objectively beyond 12 months.

To follow up two effective pedometer interventions, to establish whether objective 12-month PA effects were maintained at 3-4 years.

Long-term follow-up of 2 trials: PACE-UP 3-arm (postal, nurse-support, control) at 3 years; PACE-Lift 2-arm (nurse-support, control) at 4 years post-baseline. Randomly selected patients from 10 UK primary care practices were recruited (PACE-UP 45-75 year olds, PACE-Lift 60-75 year olds).

Intervention arms received 12-week walking programmes (pedometer, handbooks and PA diaries) by post (PACE-UP) or with nurse-support (PACE-UP and PACE-Lift). Main outcomes were changes in 7-day accelerometer average daily step-counts and weekly time in moderate-to-vigorous PA (MVPA) in 10 minute bouts in intervention versus control groups, between baseline and 3 years (PACE-UP) and 4 years (PACE-Lift).

PACE-UP 3-year follow-up was 67% (681/1023), PACE-Lift 4-year was 76% (225/298). PACE-UP 3-year changes in PA levels from baseline were higher in intervention groups than controls: additional steps/day postal +627 (95% CI 198-1056) p=0.004, nurse +670 (95% CI 237-1102) p=0.002; total weekly MVPA in bouts (minutes/week) postal +28 (95% CI 7-49) p=0.009, nurse +24 (95% CI 3-45) p=0.03. PACE-Lift 4-year intervention versus control comparisons were: +407 (95% CI -177 to 992) p=0.17 steps/day; and +32 (95% CI 5-60) p=0.02 minutes/week MVPA in bouts. Neither trial showed sedentary or wear-time differences. Main study limitation was incomplete follow-up, however, results were robust to sensitivity analyses for missing data effects.

Both trials demonstrated novel, long-term increases in objectively measured PA, substantially maintained from previously reported 12-month effects. Pedometer interventions, delivered by post or with nurse support, can help address the public health physical inactivity challenge.
3. Managing potentially avoidable consultations in General Practice: An audit on Grafton Medical Partners

Angelos Mantelakis, Dr Stephen De Wilde, Dr Adrian Brown.

In the past decade, annual consultations per person, mean duration of consultations and overall workload have all significantly increased1. There are now concerns that the ability of GP services to meet the increasing demand is plateauing1. It is estimated that 27% of all doctor consultations could be referred to other healthcare professionals or prevented altogether (through advice on self-care or request for documentations), and is advocated as a promising way to reduce workload.

Based on this, the aim and objectives of the audit are:

Investigate the amount of avoidable consultations in Grafton Medical Partners London that could be referred to other healthcare professionals and compare its performance against national literature.

Interview staff members to determine their work boundaries.

Propose an action plan, based on these work boundaries, to refer these patients to the appropriate healthcare professionals during their first contact with the practice.

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Interview staff members to determine their work boundaries.

Propose an action plan, based on these work boundaries, to refer these patients to the appropriate healthcare professionals during their first contact with the practice.

Healthcare Professional interviews

Semi-structured interviews were performed, inquiring current roles and responsibilities of a pharmacist, asthma specialised nurse, healthcare assistant and receptionist. Their confidence in performing consultations inside these roles that are currently seen by doctors was also evaluated.

Quantitative Data

A sample of 60 patient-doctor consultations throughout the year (5 patients per calendar month) was collected. Simple randomisation was performed using Google’s random number generator for patients ID code and their month of appointment to be sampled.

No data was extracted from the practice, and all interviewees and patients were anonymised.

The pharmacist and specialist nurse felt confident in providing consultations that are currently reviewed by doctors. These include medication reviews/ minor ailments (pharmacist), asthma review (specialised nurse). The healthcare assistant and reception felt confident in triaging patients, but not in performing any doctors consultations.

Of the 60 consultations audited, 15 could potentially be avoided (25%). The percentage of patients that could have been seen by a pharmacist was 13% (8 patients) versus 2% reported in the literature. Consultations that could be referred to someone else in the practice was 10% (6 patients), compared to 6.5%3.

Grafton Medical Partners undertake the same proportion of potentially avoidable consultations as the rest of Britain. However, from these avoidable consultations, the amount that could be referred to pharmacists and other healthcare professionals was higher than that reported in the literature.

The responsibilities reported by the pharmacist, specialised asthma nurse, healthcare assistant and receptionist agree with those reported in literature, and are relevant to tailor a future action plan.

Based on these findings, Grafton Medical Partners may reduce overall costs and increase access to patients with non-minor ailments by referring patients appropriately to pharmacists. This can be done through effective triaging during first patient contact. Patients will be asked whether their presenting symptom falls under the Minor Ailments category (using an already available Triage Form -reference). If patients’ symptoms fall under this category or medication review, they will be booked for a consultation with a pharmacist, otherwise, they will be booked with a GP. Patients will be informed about who they will see, and if they insist on seeing a doctor their request will be granted.

Implementation
Organisation of a workshop and defining clear goals with measurable outcomes, division of labour, training, and communication to all team members. A training period will be set for 1 month, at the end of which feedback from patients/staff will be gathered. Modifications based on these will be made, and then the results will be re-audited in the same methodology after 12 months with a target of referring 98% of the appropriate consultations to pharmacists.
4. Optimising follow-up at seven months in ethnically diverse, sexually active 16-24 year olds taking part in the “Test n Treat” feasibility trial of rapid chlamydia/gonorrhoea tests

Alastair Green, Sarah Kerry-Barnard, Charlotte Fleming

“Test n Treat” is a NIHR funded cluster-randomised feasibility trial aiming to assess the feasibility of conducting a future trial in FE colleges to investigate if rapid, on-site testing and treatment reduces chlamydia/gonorrhoea rates in sexually active students aged 16-24 years.

At the outcome assessment at seven months, participants were asked to provide self-taken genitourinary samples and completed a questionnaire in college, and were given £10. However, over half of participants (57%, 143/252) from three colleges did not attend follow-up.

1. To investigate the final response rate in obtaining samples and questionnaires from 143 trial participants who did not attend follow-up at seven months in three colleges.
2. To measure the work involved in obtaining these samples and questionnaires.

We texted all 143 non-attenders a link to the follow-up questionnaire online. This included an option to meet in college to provide a sample or be sent a postal testing kit. Non-responders were telephoned a maximum of twice.

Ten days after sending postal kits, we called those who had not returned them and/or completed questionnaires up to twice more. Students providing samples were texted results, and given £10. Those with infections were contacted by the nurse health advisor.

Numbers followed up were recorded. All communication and the time taken was documented to assess work involved.

We obtained data on 41 of 143 participants who did not attend follow-up at seven months in college. This increased the overall response rate in the three colleges from 43% (109/252) to 60% (150/252). This took 14 hours 10 minutes to complete.

“Test n Treat” is the first UK study using rapid chlamydia/gonorrhoea tests in FE colleges, focusing on a hard to reach population of ethnically diverse sexually active teenagers. The results show that the methods used can achieve an important (17%) increase in response rate.
5. Does Weather Impact on GP Home Visitation?

Mr. Olaoluwa Oyawoye, Dr. Melvyn Jones.

GPs are under immense pressure with high workloads. Home visits still represent a significant part of their jobs, with 13.6 million conducted in the UK in 2014. Previous research has been done on the effect of weather and pollution on consults in healthcare. Significant results could have implications for local guidelines, policies and planning with weather forecasts.

To explore the relationship between different meteorological variables and home visit rates conducted by GPs in Hertfordshire.

Univariate Poisson regression analyses were undertaken with volume of home visits and each meteorological variable, then a multivariate analysis was done. This was a cross sectional study. The meteorological variables were daily temperature, daily total rainfall, daily number of hours of sunshine and daily number of hours with relative humidity equal to, or above 90%.

Univariate Poisson regressions: statistically significant 0.005% decrease in the likelihood of a home visit for each degree Celsius increase in maximum and mean temperature and a statistically significant 0.004% decrease in the likelihood of a home visit for each degree Celsius increase in minimum temperature.

No correlation was found between the volume of conducted home visits and the amount of rainfall per day. There is a 0.004% decrease in the likelihood of a home visit for every one-hour increase in total sunshine. There is a statistically insignificant 0.002% increase in the likelihood of a home visit for every one-hour increase in duration of high relative humidity.

The multivariate Poisson regression showed that there is as a 0.005% decrease in the likelihood of a home visit for each degree Celsius increase in maximum temperature. Daily minimum temperature, daily total amount of rainfall, daily number of hours of sunshine and daily number of hours with relative humidity equal to, or greater than 90% showed no significant correlation with the number of home visits conducted daily. Mean temperature was a redundant parameter in the multivariate regression.

The results show very small correlations in the univariate analyses, most of which disappeared on multivariate analysis. Unlikely to be any real-world effect of weather on home visit rates. The inclusion of flu data and pollution could add an important variable, and should be considered in future research.
Does the ethnic density effect extend to obesity? A cross-sectional study of 415,166 adults in East London

Shailen Sutaria, Rohini Mathur, Sally Hull

Does the ethnic density effect extend to obesity? A cross-sectional study of 415,166 adults in East London

Obesity is a major public health concern and varies significantly by ethnicity.

The ethnic density effect describes the association between increasing ethnic density, measured as the proportion of same ethnic grouping living in the same geographical area, and improved mental and physical health measures. In the United Kingdom (UK), such associations have been described in the areas of mental health and more recently in smoking behaviour, however it is unknown whether this effect extends to obesity.

We aimed to report the odds of obesity among different ethnic groups and examine whether the odds of obesity within ethnic group varies by neighbourhood level measures of own-group ethnic density.

This was a cross-sectional study utilising electronic primary care records of 136 practices in a multi-ethnic population of east London.

Using multi-level logistic regression we examined the odds of obesity by ethnic group and examined the association between increasing ethnic density and odds of obesity, reported by sex and ethnic group.

Obesity prevalence was 23% in the study population, with highest prevalence among black African and Caribbean groups (39%) and lowest among Chinese (5%). Compared to white British/Irish males, risk of obesity was significantly higher among black ethnic groups and significantly lower among Asian and white other minority groups. Among females, all ethnic groups except Chinese and white other were at increased risk of obesity compared to white British/Irish. There was no association between increasing ethnic density and obesity, except among black Africans, where a 10% increase in ethnic density was associated with a 15% increase in odds of obesity among males (95%CI 1.07-1.24) and 18% among females (95%CI 1.08-1.30). This association was not present among adults under 35 years of age.

Environmental factors may play a greater role in determining obesity than the ethnic composition of the area for most ethnic groups except black Africans. Further research is needed to understand the mechanism through which increasing ethnic density is associated with increase risk of obesity solely among black African ethnicity.
7. Supporting ethical decision making for clinical commissioners - an interview study

Selena Knight.

With increasing demand on NHS services and containment of the health budget, difficult decisions about how to allocate scarce resources will necessarily become more commonplace. The responsibility for many of these decisions falls upon CCG members, exposing them to difficult ethical dilemmas. Although existing literature considers ethical issues in resource allocation generally, there is little empirical research to understand how dilemmas are perceived by those actually making such decisions.

This study aims to provide greater insight into the ethics background with which commissioners approach their role, and to identify and better understand their ethics learning needs. The objectives are to:

- Establish whether commissioners identify themselves as having ethical learning needs in relation to their role.
- Understand the tools/background they currently use to assist them in addressing ethical dilemmas.
- Understand what form(s) of ethics education/support commissioners perceive could be provided to help address unmet ethics learning needs.
- Consider how the impact of such ethics education/support might be evaluated in this context.

Semi-structured interviews will be carried out with CCG members from a range of backgrounds (primary care, other clinical, and lay members). Participants will be recruited from at least 3 different CCGs. Qualitative analysis of transcribed interviews will be undertaking using framework analysis.

Results are pending, with initial findings and preliminary analysis due prior to the meeting.

The findings of this study can be used as a starting point for developing an educational intervention or ethics support system for commissioners, which may be implemented and evaluated in future work. This research will contribute to commissioners being better supported to make fairer decisions which stand up to both legal and ethical scrutiny, benefitting both patients and society as a whole.
8. Moving research findings into practice; website and mobile app development and feasibility testing for implementation of the PACE-UP walking intervention in 45-75 year old primary care patients

Charlotte Wahlich, Cheryl Furness, Derek Cook, Elizabeth Limb, Sarah Kerry-Barnard, Tess Harris

Moving research findings into practice; website and mobile app development and feasibility testing for implementation of the PACE-UP walking intervention in 45-75 year old primary care patients.

PACE-UP is a 12-week pedometer-based walking intervention which effectively increased objectively measured physical activity (PA) in inactive primary care patients, at 12-months and 3-years. 10% recruitment suggested further implementation research was required. An increase in online resources and wearable physical activity (PA) devices encouraged integration of PACE-UP with digital resources. The extended MRC complex intervention trial framework including implementation research, structured the process of translating research findings into practice.

To:

- Develop and test out a website and mobile app allowing patients to follow the walking intervention digitally;
- Test out participant uptake from different primary care recruitment pathways.

Recruitment is via three primary care routes from three South London practices with 40-75 year old inactive patients:

i. Through NHS Health Checks where low PA is identified

ii. As part of routine GP or nurse consultations where low PA is identified

iii. By post to individuals classified as “inactive” from a previous NHS Health Check

Interested participants will receive a pedometer pack (including 12-week walking intervention and handbook). They can follow the walking programme online, via the mobile app or using paper resources.

The number of pedometer packs offered versus the number taken up will be recorded via different recruitment routes. The number of patients using the website and app will be monitored.

We will present the MRC implementation cycle showing steps taken to help move the PACE-UP intervention into practice, including the process of developing a website and mobile app. Initial uptake results from different recruitment pathways and different choice of intervention engagement (paper-based, online, app) will be presented.

Development and recruitment results and challenges and the implications of the research for future plans to roll out the intervention into routine primary care, to help address the public health physical inactivity challenge, will be discussed.
9. The first steps to fostering international communities of practice: An exploration of the attitudes of Japanese trainees to navigating the academic professional environment of general practice in the UK.

Dr Maham Stanyon, Dr Makoto Kaneko

The future of primary care lies in successful international collaboration. Anecdotally exchange programs place participants in clinical rather than academic environments, however most collaboration occurs in the latter. Therefore the skills to navigate transcultural-academic professional behaviours must be recognised and developed.

Professional interactions in the UK and Japan differ significantly, best described in terms of Hall’s high vs low context communication1, and Hofstede’s individualism vs collectivism cultural dimensions model. The Undergraduate Department of Primary Care at Imperial has developed educational communities of practice (eCoP) based on social learning principles by Lave and Wenger. Through working alongside UK GPs and trainees, Japanese trainees may gain experience navigating our academic behaviours whilst providing an insight into their own, leading to mutual appreciation of the rules of our respective professional hidden curricula.

To determine if exposure to social learning in our eCoP model is effective in facilitating skills to collaborate more effectively and promote shared understanding of our respective professional hidden curricula.

A translated questionnaire incorporating free-text answers and a Likert scale will be distributed amongst a group of Japanese GP trainees, exploring attitudes to interacting in a western working environment. Volunteers will be sought to participate in the two week programme of academic immersion, interacting with members of the eCoP. Participants and eCoP members will undertake a post-experience questionnaire, with the results analysed through a paired T-test and thematic analysis.

Data collection is forthcoming; we hope to present the pre-immersion data at Madingley. Through participation in our eCoP model we hope to show it can be used to improve the confidence of international trainees in engaging effectively as members of our academic community. We feel trainees may better understand the behaviours that govern our professional interaction and share the professional hidden curriculum of their own culture. This shared understanding may facilitate increased collaboration, ultimately fostering international communities of practice.

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Dr Sonia Kumar, Dr Arti Maini and Jo Horsburgh

Department of Undergraduate Primary Care and Public Health, Charing Cross Campus, Imperial College, London, UK
10. Developing a theoretically grounded, gamified health app: lessons from designing the smoking cessation game Cigbreak

Dr. Elizabeth Ann Edwards, Ms. Hope Caton, Professor Robert Walton

Developing a theoretically grounded, gamified health app: lessons from designing the smoking cessation game Cigbreak

Gaming techniques are increasingly recognised as effective methods for changing behaviour and increasing user engagement. The rapid uptake of smartphone games provides an unprecedented opportunity to reach large numbers of people and to influence a wide range of health related behaviours. However, digital interventions are still nascent in the field of healthcare, and optimum methods of achieving health behaviour change using games are still being investigated. There is currently a lack of worked methodologies that app developers and healthcare professionals can follow to aid in theoretically informed design of gamified health applications.

We present a framework to guide development of gamified health apps, using our recently completed app Cigbreak as an example.

We adopted a systematic approach: 1) forming an expert multidisciplinary design team, 2) gaining an understanding of the research problem, 3) establishing user preferences, 4) incorporating a domain specific evidence base, 5) incorporating validated behavior change techniques, 6) incorporating gamification, 7) developing a logic model, 8) using an iterative development process.

Players found Cigbreak an engaging and motivating way to gain smoking cessation advice and a helpful distraction from smoking; 84% of smokers said they would play again and recommend to a friend.

A dedicated game to promote smoking cessation has potential to distract smokers during cravings and to deliver effective smoking cessation advice. Iterative collaborative development using evidence based theory, behaviour change techniques and gamification have ensured the game is engaging and incorporates a strong evidence base with validated behaviour change techniques. We plan to evaluate the game in a clinical trial.

Rohini Mathur, Gavin Dreyer, Sally Hull.

Chronic kidney disease (CKD) is one of the most common complications of diabetes mellitus. In the UK it is estimated that up to 30% of patients with type 2 diabetes (T2DM) have CKD stages 3-5. Ethnic minority groups are known to have a higher prevalence of T2DM and end stage renal failure (ESRF) as compared to the white majority population. Whether this excess of ESRF is a result of faster progression of CKD in ethnic minority groups remains poorly understood.

To determine ethnic differences in the progression of chronic kidney disease (CKD) and risk of end stage renal disease (ESRF) and death in adults with type 2 diabetes (T2DM), and to identify predictors of rapid renal decline.

An observational cohort study of 6,274 adults in east London with established type 2 diabetes and CKD was undertaken. Renal decline, stratified by proteinuria and hypertension, was compared between ethnic groups. Risk factors associated with rapid CKD progression were identified and ethnic differences in the risk of end stage renal failure (ESRF) and death were determined.

The annual rate of eGFR decline for the whole cohort was -0.86 ml/min/1.73m² (95% CI -0.83, -0.89) and fastest for the south Asian group after accounting for the combined effect of proteinuria, raised BP and key confounders (-1.94 ml/min/1.73m² 95% CI -2.15, -1.73). Risk factors for rapid CKD progression included Bangladeshi or black ethnicity, male gender, hypertension, proteinuria, CVD, and increasing duration of diabetes. Rapid progression was inversely related to age. Risk of developing ESRF was highest in the black group compared to the white group (HR 1.88, 95% CI 1.11-3.19). Risk of death from any cause was 29% lower in the south Asian group compared to the white group (HR 0.71, 95% CI 0.56-0.91).

Proteinuria and hypertension trigger accelerated eGFR decline differentially by ethnicity. South Asian groups had the fastest CKD progression, but lowest risk of death relative to the white group. Active monitoring of younger adults, who have greater odds of rapid progression and the most to gain from interventions, is essential.
12. Care plan use amongst frail older people: analysis of the 2015-16 General Practice Patient Survey

Alice Shiner, John Ford, Nicholas Steel

Care plans can improve health in frail older people, particularly when patients engage in the care planning process [1], and they are recommended for primary care [2]. However, previous research suggests that few patients report having a written care plan [3, 4], and no studies have examined how many of frail older people report having a care plan or are engaged in the care planning process.

To identify characteristics of frail older patients who report having a care plan and who engage in care planning, and associations with out-of-hours (OOH) contacts.

Data from the General Practice Patient Survey 2015-16 in England was analysed using Stata. Associations between having a care plan and being engaged with care planning and age, gender, ethnicity, deprivation, multimorbidity, experience and confidence in general practitioner (GP), and other variables were estimated with logistic regression. Associations with OOH contacts were estimated using regression analysis.

3.5% of all GPPS respondents and 14.4% of frail older people reported having a care plan. Only 1 in 4 frail older people with a care plan were engaged with the care planning process. Engagement with care planning was associated with seeing own GP (odds ratio (OR) 1.88, 95% confidence interval (CI) 1.48 to 2.38) and factors that reflected a positive interpersonal relationship with the GP, including having confidence in the GP (OR 5.92, CI 2.38 to 14.77). Respondents who were engaged with care planning were no more likely to contact OOH than those who were not engaged with their care plan.

Few frail older patients report having a care plan, and fewer report engaging in the care planning process. This may reduce the ability of care plans to deliver health benefits.
Social media is used by individuals with medical conditions. Invisible long-term medical conditions with variable presentations such as migraine may leave individuals seeking support and information. Research can delineate the benefits and harms of using social media in the context of different long-term medical conditions. How and why individuals with migraine are using social media has yet to be investigated.

We aimed to describe how people with migraines use social media and how having migraines are reflected in their sense of self and online identity. We also aimed to identify harms of social media use in a health context.

Twenty participants who experienced migraine were recruited via migraine-specific charities. Semi-structured interviews were conducted with questions based on a topic guide. Interviews were transcribed verbatim and transcripts were analysed via thematic analysis.

Our findings suggest that people with migraine are using social media to obtain information to better understand their condition and treatment options. Social media can offer people with migraine instant access to continuous information and social support from empathic others. The opportunity to pool subjective lived-experience of migraines on social media was seen as invaluable. This exchange of social support and information was viewed as mutually beneficial. Participants also viewed social media as an outlet to vent frustrations and to validate their migraine experience. They referred to the invisible and episodic nature of migraine which may contribute to societal misunderstanding of the impact and/or severity of the condition. There was variation in how participants felt their migraines were part of their online and offline identity. Some participants masked their online migraine-related behaviour, using different sites or closed online groups to determine who saw their migraine-related content. Utilising social media enabled participants to retain desired elements of their identity depending on how the user chose to engage with the platform. Participating in closed social media groups sometimes changed online behaviour in other areas of the platform. This illustrates the role of individual differences, as well as the complex relationship between migraine, social media and identity. Harms of social media were identified including accuracy of information, negativity, privacy issues and screen use difficulties.

How migraine is part of one’s identity and represented online varies between individuals. Social media can provide people who experience migraines with instant and continuous access to social support and health information, from a group of empathic others with lived-experience of the condition. Social media appears to help validate the illness experience of migraine, as well as provide reassurance and help to reduce feelings of isolation.
14. What is the prevalence of the most common influences on medication adherence in the elderly on polypharmacy?

Firdaws Nackvi, William Coppola.

There is limited research on this topic. The study aimed to identify the prevalence of the most common influences on medication adherence in the elderly on polypharmacy.

Secondary aims: to identify what interventions patients want to help them adhere, causes of intentional non-adherence, possible relationships between medical conditions and poor adherence as well as between medication type and poor adherence. Finally, to identify possible relationships between unplanned hospital admissions and side effects or medication number.

A questionnaire was distributed to patients in a North London practice, who were identified as eligible by asking if they were over the age of 65 and on five or more medications. A total of 150 questionnaires were distributed. A total of 71 patients took part in the study.

The most common reasons for non-adherence were experiencing side effects (26.8%), having to take medication more than once daily (25.4%) and 43.7% of patients responded with ‘other’. Common responses in the ‘other’ section were reading about side effects online, medications running out and feeling well.

The most desired interventions were a dosette box (39.4%), talking to a pharmacist or GP about side effects (22.5%) and having a pharmacist medication review (medicines use review) (21.1%).

No statistically significant difference in adherence rates was found in those with type 2 diabetes mellitus, hypertension or high cholesterol. Between those who had type 2 diabetes or hypertension (P = 0.500), type 2 diabetes or high cholesterol (P = 0.326) or high cholesterol or hypertension (P = 0.08).

No statistically significant difference was found between unplanned hospital admission and experience of side effects (P = 0.736) or between unplanned hospital admission and number of regular medications (P = 0.053).

No statistically significant correlation was found between unplanned hospital admission and medication number (P = 0.424).

The most prevalent issues causing non-adherence were identified. Where possible, less complex dosing schemes may need to be considered for certain patients. There is a necessity for patient education on side effects and benefits of taking medications, as well as rationale behind prescribing decisions. Some patients who may require medications delivery services are not identified, resulting in unintentional non-adherence. Dosette boxes are a useful way of improving adherence and need to be continued to be offered to eligible patients. Pharmacist medicines use reviews need to be employed more and patients should be made aware of their availability and importance, in order to improve adherence to medication.
15. An evaluation of sexual health services provided in Lewisham Community Pharmacies

Zeinab Ruhomauly.

Improving sexual health is a priority Public Health outcome by Lewisham’s Health and Wellbeing Board(1). Twenty pharmacies are commissioned to provide Patient Group Directions (PGDs) for Emergency Hormonal Contraception (EHC); appropriate counselling; chlamydia screening. Previous research evaluating the needs of service users found 57% of women presenting for EHC in pharmacies were not using other forms of contraception(2). There was interest in being able to access other contraception options in pharmacy. The 2015 Lewisham Pharmacy Needs Assessment recognised the potential for further extension of sexual health services in pharmacies alongside EHC(3).


1) To assess community pharmacists’ views regarding the current provision of sexual health services
2) To assess compliance methods with current PGD requirements

An online questionnaire was sent to 20 pharmacies offering EHC and sexual health nurses and a GP manager interviewed.

- 50% of pharmacists refer patients repeatedly seeking EHC to their local GP or sexual health clinic
- 3 pharmacies have leaflets advertising their services in local GPs
- 5 out of 15 pharmacies offered chlamydia screening as part of EHC consultations
- Sexual health nurses expressed concern about access, waiting times and confidential support for young people and supported increased service provision in pharmacies but Practice managers were concerned about reduced funding

Collaboration could be encouraged between local pharmacies, GPs and sexual health clinics to increase signposting of services, especially to increase accessibility of specialist GP services.

A third of pharmacies are currently adhering to all EHC PGD requirements. Although increased provision of clinical services in pharmacies has potential to alleviate pressures in primary care, this study indicates sub-optimal implementation and the importance of quality of services provided in pharmacy.

From this study, a set of recommendations for sexual health service provision was also produced for Lewisham Public Health.
16. Palliative care in general practice: cancer patient’ and carers’ experience of their GP’s role

*Emilie Green, Patrick White, Heidi Lempp*

Palliative care in general practice: cancer patients’ and carers’ experience of their GP’s role

It is increasingly recognised that palliative care is a core part of the work of generalists. General practitioners (GPs) are well positioned to ensure coordination and continuity of care for patients, including at the end of life. Little is known about how patients understand the role of their GP in delivering palliative care in the community.

To explore patients’ and carers’ experience of:

1. The role of the GP in providing palliative care to adult patients with cancer
2. The facilitators and barriers to the GP’s capacity to fulfil this perceived role

Qualitative data will be obtained through semi-structured interviews with adults with cancer and palliative care needs (known to St Joseph’s Hospice, Hackney). Patients will be invited to bring their carer to the interview.

Findings will facilitate clearer definition of the GP’s role, from the perspectives of services users. Continued research is crucial to influence future practice and policy development, and support a more tailored, patient-centred approach to service design and delivery of end of life care.
17. The Sessional GP Tutor and Host Practice Matching Scheme - a novel way of expanding teaching opportunities for medical students in Primary Care

Dr Jenny Blythe, Lynne Magorian.

The number of medical students is increasing and external pressures mean more of their teaching is expected to have a community focus (HEE). At the same time, the number of GPs in locum positions is increasing, and this group have traditionally been less involved in undergraduate teaching as they have been more hard to reach. Finally, we also have established teaching practices who have the physical space to host teaching but not the workforce resource to commit to teaching. In order to ensure that all medical students continued to receive quality GP-led teaching in small groups, we aimed to recruit and retain Locum GP with previous teaching experience and develop and group of sessional GP Tutors, and 'match' them with established teaching 'host' practices. We contacted both our larger approved teaching practices and practices who had declined teaching for the current academic year who had cited resource issues as a cause. We advertised for Sessional GP Tutors via local locum websites, social media and by personal contacts in the GP department.

We asked potential Sessional GP Tutors to send in their educational experience CVs, and met them all on individual basis prior to teaching for the medical school. In order to provide group information and support, it was decided that all Sessional GP Tutors should be allocated to teach the same block of teaching.

In academic year 2016/7, a total of seven Sessional GP Tutors were recruited and they each took a once weekly group of four students for one day per week for a term at a host practice. It was the host practice responsibility to identify and arrange for patients to come in and provide the physical resources for effective teaching. A joint handbook for both host practices and Sessional GP Tutors was developed to ensure clarity in terms of indemnity, patient and student responsibilities. Sessional GP Tutors were paid a flat rate for their session of teaching, and practices either received a lump sum or a tiered increase in facilities payment, depending on what other teaching they had committed to over that academic year.

In academic year 2016/7, a total of seven sessional GP tutors were recruited and they each took a once weekly group of four students for one day per week for a term at a host practice. A total of 28 third year students were involved. There were no difference in either their satisfaction rates or their term exam results in comparison to students who attended a practice using the traditional format scheme. Students commented positively that the "tutor was there...just for us" but acknowledged that they did not experience other elements of the practice eg time with nurses or sitting in on general clinics. One practice used a hybrid model, splitting teaching between the host practice and the sessional tutor, and this was well received by the students.

Sessional GP Tutors enjoyed the opportunity to teach, and also commented positively about developing a professional relationship with the host practice, on occasion going back to work there clinically as a Locum.

Host practices commented positively about how the scheme helped them to maintain a teaching environment, as well as the financial benefit.

The Sessional GP Tutor and Host Practice Scheme was an innovative way of both maintaining quality placements in terms of student numbers and overall was well received by all parties involved. Furthermore, it expanded the pool of capable and enthusiastic GP Tutors to a previously hard to reach (but currently expanding) group of GP Clinicians.
Anaphylaxis is a severe systemic allergic reaction that can be life-threatening. There are many triggers of anaphylaxis, including food and medication. The number of patients diagnosed with allergies and the number of prescriptions for EpiPens have been rising over the past 20 years. A UK study (1992-2012) reported a six-fold increase in hospital admissions for all patients with anaphylaxis (Turner et al., 2015). Whilst numerous studies have been conducted on knowledge of anaphylaxis among healthcare workers, there is little research on clinicians’ perceptions and attitudes.

To explore knowledge and attitudes of healthcare workers towards anaphylaxis treatment and management using 1:1 interviews. Face-to-face, semi-structured interviews were conducted with primary healthcare professionals recruited from general practice in London. The participants were recruited through convenience sampling. The interviews were recorded, transcribed and analysed using a thematic approach. Six interviews were conducted by a 3rd year UCL medical student in the study.

Two themes emerged: knowledge and reality:

1. Healthcare workers in primary care reported on their knowledge of anaphylaxis treatment and patient management. They recognised that the responsibility in providing advice to patients is shifting from hospitals to general practice. Clinicians emphasized the rarity of acute anaphylaxis but knew that treatment is life-saving.

2. Most participants believed all staff in a primary care setting should be trained to manage anaphylaxis, with most preferring face-to-face, practical training. The participants emphasised some difficulty in recognising anaphylaxis and uncertainty of doses required in children.

It is important to understand healthcare workers’ knowledge and attitudes in treating and managing patients suffering with acute anaphylaxis. This pilot study reveals concerns about recognizing anaphylaxis and providing the right treatment; findings which have been noted previously. Further research is needed to explore the area on a larger scale.

Dr Umar Chaudhry, Ms Charlotte Wahlich, Professor Tess Harris.

Physical inactivity is a growing public health concern. Previous systematic reviews have identified pedometers as a means to improve physical activity (PA) levels; however, several new large clinical trials have added to the evidence-base. Furthermore, newer step-count monitoring interventions (for example, phone applications and body worn devices) have since emerged that require scrutiny as part of a broader review.

Primary Objective: How do community pedometer and other step-count monitoring interventions affect PA levels of the adult general population?

Secondary Objective(s): Are certain interventions more effective than others? How do intervention effects vary with time? What are the effect-modifiers of PA maintenance?

A detailed search using MeSH headings and keywords to identify randomised controlled trials published after 1st January 2000 shall be conducted within the following databases: MEDLINE, EMBASE, PsycINFO, CINAHL, Cochrane CENTRAL, Web of Science and ASSIA. Community-based participants, aged ≥18 with no medical conditions/risk factors to prevent them undertaking physical exertion shall be included. The intervention shall involve pedometers or other step-count monitoring interventions as PA objective measures, versus usual care. The study shall be conducted according to PRISMA protocols.

The primary outcome is change in step-count between baseline and follow-up. Secondary outcomes involve distance travelled, time spent walking or in moderate-to-vigorous PA. Two independent reviewers shall perform the search, study selection, study appraisal and relevant data extraction. Meta-analysis using a random-effects model, sub-group analysis and risk of bias assessment shall also be undertaken. Available results and the challenges faced in conducting the systematic review will be presented.

When completed, this review will inform our understanding of the use of pedometer and other step-count monitoring interventions on PA. The practicalities of conducting the review, the difficulties encountered and methods of overcoming these will be discussed. Systematic review registration: PROSPERO CRD42017075810.
“Ooooh, I’m famous!” Challenges in capturing naturally occurring talk in medical consultations

Maureen Seguin, Laura Hall, Fiona Stevenson

Much of the research on interactions between physicians and patients during medical consultations draws upon retrospective accounts of both. However, what people say they do differs from what they actually do. As effective strategies to increase consultation time efficiency and patient satisfaction with medical care hinge upon a clear understanding of how patients and physicians interact, this discrepancy has damaging implications.

The aim of the study is to address the disparity between retrospective accounts of consultations by patients and GPs versus what actually happened during a consultation.

Data is being collected from GP surgeries in England. Approximately 200 video recordings of GP consultations have been completed, out of our aim of 300. These are complemented by 30 post-consultation interviews with patients, 10 post-consultation interviews with physicians, an enrolment log tracking all potential participants, and field notes recorded by research associates. Details on how physicians and patients oriented toward the video camera during the consultation, are being analysed thematically using Nvivo.

Preliminary results suggest that some patients declined involvement in the study due to concerns over their appearance, the perceived sensitivity of their medical problem, or perceived risk to their own or their child’s anonymity. Of those who took part, many patients looked at the camera and some address an imagined audience. Despite these instances, both physicians and patients reported via post-consultation interviews that they conducted themselves “on-camera” as they would have done “off-camera”.

The difficulty in establishing “what actually happens” during medical consultations is hampered by the considerable proportion of patients who decline to have their consultation recorded. Moreover, patients and GPs are aware of the recording equipment, which may impact upon their interaction. Thus, capturing “what actually happens” during medical consultations is not as straightforward as video recording consultations.
21. Harnessing resources from the internet to maximise outcomes from GP consultations (HaRI): a qualitative study

Maureen Seguin, Laura Hall, Fiona Stevenson.

The doctor-patient relationship has acknowledged therapeutic power. Societal changes such as patient access to previously privileged health information via the internet and increasing emphasis on self-management are fundamentally altering the GP-patient relationship. Patients who go online for health information may be reluctant to share this with their doctors. Similarly, many GPs report concerns about how best to respond when patients introduce such information in consultations. Much existing research relies on retroactive reports from patients and doctors following consultations, yet what people say they do differs from what they actually do.

The aim of the study is to suggest strategies to improve GP-patient interactions regarding patient’s access of online health information. Questionnaire data will determine the help sought and information sources accessed by patients prior to consultations. Consultations will be video-recorded (n~300) and conversation analytic methods will be used to identify patterns of interaction and the consequences of what is said to better understand the use of the internet in consultations. Interviews with the GPs (n=10) and patients (n=30) after their consultations will be analysed thematically to illuminate the perceived barriers and facilitators to disclosing or promoting discussions of online health information in consultations.

Strategies used in consultations by both GPs and patients, together with their interactional consequences, will be presented.

Evidence of strategies that make discussion of materials from the internet smoother will aid both GPs and patients in the potentially interactionally-fraught area of discussion of the internet in consultations.
22. The Virtual Toddler study into undergraduate paediatric development teaching: a comparison of a novel blended learning session utilising virtual simulated patients and traditional didactic teaching.

*Dr Elinor Gunning, Dr Senita Mountjoy, Dr Emma Keeling*

The Virtual Toddler study into undergraduate paediatric development teaching: a comparison of a novel blended learning session utilising virtual simulated patients and traditional didactic teaching. Paediatric child development is an important component of both undergraduate and postgraduate Paediatric and General Practice curricula. Traditionally this is taught didactically, with limited opportunities for paediatric development clinic attendance.

However, the literature suggests development is best learnt experientially(1), and students consistently feedback on the value of child-student interactions. In light of increasing student numbers, and ethical and practical issues around involving paediatric patients in teaching (1), educators need to consider how to best deliver standardised experiential learning opportunities.

Our novel “Virtual Toddler Session” (VTS) aims to simulate a child developmental assessment using facilitated group eLearning; a blended learning approach. We have built upon previous literature (2), incorporating reflexivity with students leading examination of a virtual simulated patient. Blended learning improves medical student newborn examination skills (3), but evaluation of virtual patients and blended learning to teach paediatric clinical skills is limited in the literature.

Knowledge was assessed in both groups via an MCQ pre- and post-rotation.

Attitudes and satisfaction of group 1 were evaluated via a post-session questionnaire.

Initial thematic analysis of questionnaire responses from VTS attendees suggest students perceive this session as a useful experiential learning opportunity putting the didactic lecture into context, and providing opportunity for practice and consolidation.

Final results will be presented at the conference.

Our novel VTS blends eLearning and small-group facilitated teaching to enhance provision of experiential learning opportunities for paediatric developmental assessment.

Virtual simulated patients and blended learning may standardise learning experiences, increase access to child development cases, and be generalizable to other areas of medical education.
23. Teaching the student apprentice: The barriers and benefits for GP tutors undertaking two novel longitudinal primary care attachments.

Dr Shivani Tanna, Dr Andrew McKeown, Dr Ravi Parekh.

Imperial College London is phasing in innovative longitudinal clinical attachments in General Practice in year three and five of the MBBS programme. This is part of local and national priorities, to ensure future doctors are taught skills in generalism and professionalism and have meaningful relationships with their patients. It is also hoped that such early and prolonged exposure to primary care, may help address the current GP recruitment crisis. In the UK only 35% of practices teach medical students1. Therefore, in order to deliver more education in the community a better understanding is required of the barriers and motivations for undergraduate teaching.

As part of the evaluation of these attachments we are exploring the difficulties and benefits that tutors involved in these longitudinal clinical attachments may have encountered.

All tutors undertaking our third and fifth year longitudinal pilot attachments at Imperial College School of Medicine in 2016/2017 (n= 27) were invited to complete a survey at the end of the academic year. Preliminary data shows a response rate of 80%.

Our initial findings show 100% of respondents enjoyed the attachment and would host students again. Other motivating factors were positive contribution to personal professional development, support by medical school faculty, remuneration, positive patient feedback and improved clinical efficiency. Hindering factors were time and room space.

Our initial results support data suggesting time constraints and space are barriers to undergraduate teaching. However, using an apprenticeship type model allowing students to carry out parallel clinics and adopt patient advocacy roles seems to have transformed the tutor experience. The findings of this study suggest that longitudinal attachments can provide the opportunity for students to play an authentic active role for their patients and within their GP practice team, which may be an important factor for GP tutor recruitment and retention.
24. The Association between Oral Contraceptive Use and Risk of Breast Cancer: A Systematic Review

Bhavna Ramachandran, Nabila Rehhnuma, Dr Chantal Babb de Villiers

Oral contraceptives (OC) have been implicated in breast cancer risk. However, there is varying consensus on their exact contribution risk of breast cancer. This study aimed to more fully characterise the contribution of OC use to the risk of breast cancer by identifying types of OC and definitions of OC use, specifically in terms of duration of use and time since last use.

We updated an existing review (Gierisch et al, 2013) by systematically searching Pubmed, Embase and Cochrane Database to identify publications from January 2012. 119 articles were identified for full-text assessment, of which 19 studies met the inclusion criteria. Data were extracted from these studies by two separate investigators and collated by a third. Specific attention was paid to the exact question asked to collect information on OC use, and how it was defined.

There was heterogeneity between the 19 studies on the type and duration of OC use. Eleven studies collected data on duration of OC use; however, no association was found with breast cancer risk. Nine studies collected data on time since last OC use. While few found that risk decreased over time (n=3), no association was found in other studies. Interestingly, we noted great variability in the definitions used for ever-, never-, current and recent OC use, and thus concluded that the data were not comparable. Only seven out of nineteen studies collected information on OC formulations to varying levels of detail.

This review highlights the considerable inconsistency and variability in the data used to assess the association of OC use and breast cancer risk. Our findings emphasise the need for future studies to apply the same definitions in order to collect useful and meaningful data that will contribute to our understanding of this clinically important association.
25. An exploratory study of a specially designated breast cancer awareness campaign (“Befriend Your Boobs”) amongst Jewish girls aged between 16-18 in a Manchester school

Fabianne Viner, Dr Surinder Singh, Dr Michelle Ferris.

Carriers of a mutation in BRCA have a 40-85% lifetime risk of developing breast cancer (National Collaborating Centre for Cancer, 2013). In the Ashkenazi Jewish population, women are 10 times more likely to carry a BRCA mutation (National Collaborating Centre for Cancer, 2013) and have an increased risk of breast cancer at an earlier age (Ferris et al., 2007). Despite genetic risk, lifestyle changes can reduce the risk of breast cancer (Petracchi et al., 2011). Befriend Your Boobs (BYB) is a breast cancer awareness programme in schools with large cohorts of Jewish girls in London. This programme is acceptable and increases breast awareness (Ferris et al., no date). As Manchester has a large Jewish population (Graham et al., 2017), BYB was taken to Manchester.

This qualitative study aimed to explore the beliefs of female students at a Jewish school in Manchester after participating in BYB with regards to:

- Confirming that BYB is acceptable
- Exploring their informational needs after BYB
- Exploring their perceptions regarding promoting a healthy lifestyle in school

One focus group was held with a convenience sample of 9 Jewish girls (aged 16-18) a week after BYB. Data was analysed using the thematic framework approach (Pope et al., 2010).

Students believed that BYB was important and that it encouraged them to conduct breast self-examination. They suggested that Instagram could be used as a reminder to self-examine and of the lifestyle facts.

They wanted BYB to continue. The school could promote sport and make alterations to the food served in the canteen.

This study states possible methods to encourage the adoption of risk reducing lifestyle behaviours for breast cancer. There is evidence that BYB is appropriate and motivational. Using social media could be an effective way to remind the participants of the lifestyle advice. The school could ensure that BYB takes place annually. The school could make adaptations to their sport and nutrition policies. Before any modifications are implemented, further research is needed to confirm the findings of this study.
26. An audit evaluating the quality of care provided to patients who present with anxiety disorder to General Practice

*Arabella Watkins*

The prevalence of anxiety disorders had been increasing, and GAD was reported to be the second most prevalent ‘common mental disorder’ (CMD)\(^1\).

Data was analysed based on assessment and initial management when patients first presented with anxiety disorder. NICE guidance provided an evidence-based, contemporary standard of care to compare against.

The primary aim was to evaluate the quality of the assessment and the initial management received by patients when presenting with anxiety disorder to General Practice.

The study was an audit of clinical care, in an inner London general practice with a registered population of 12,200 people. The data was sourced from electronic patient records held on EMIS Web.

There was considerable inconsistency in the quality of care provided for people with anxiety disorder. Medicines were commonly prescribed after the first presentation (59.30%) which contradicts the NICE stepped-care model. Suicidal ideation was only screened for in 20.40% of patients, warranting significant clinical improvement in safety-netting and/or more accurate documentation in medical records.

For many patients, the standard of care could have been improved by ensuring thorough assessment early in their care pathway, followed by a suitable stepped-management. NICE advised that if anxiety disorder was managed successfully, there was the potential to improve quality of life for patients and reduce the impact of the condition on health care resources.

Recommendations included regular use of a proforma to be adopted by the General Practice, to ensure consistently high quality care across all consultations for patients with anxiety disorder. Implementation of the assessment tool within the proforma would have improved diagnostic specificity.
27. An investigation into the teaching and knowledge of paediatric asthma amongst final year medical students

Katerina Fernandova, Judith Ibison.

Background: Paediatric asthma is a common respiratory disease. Failure to control asthma exacerbations in children is increasingly being associated with poor clinical care. This is related to health care professional (HCP) knowledge, skills and education.

Aims and objectives: To evaluate the preparedness of final year (FY) medical students for the clinical management of paediatric asthma.
Objectives include the evaluation of; (1) the knowledge of FY students with respect to paediatric asthma management, (2) the educational experience of FY students with respect to paediatric asthma and inhaler techniques and (3) the confidence of FY students in the teaching and observation of inhaler technique.

Methodology: A semi-structured cross sectional survey was conducted on 100 FY students at St George’s University of London in December 2016. A 21-point questionnaire was used to investigate the study objectives. Knowledge of paediatric asthma management was objectively assessed according to guidelines via two single best answer (SBA) questions. The data was analysed to ascertain any factors associated with knowledge, experience or student confidence.
Results: 42.4% had never seen a child with an exacerbation of asthma. 22.0% never had an inhaler technique demonstration by a HCP. 59.0% of participants did not receive timetabled teaching on inhaler technique. 68.7% had never been observed teaching a child how to use an inhaler. 9.7% answered both SBA questions correctly and 47.3% answered both SBA questions incorrectly. 70% were either ‘moderately confident’ or ‘very confident’ in checking for correct inhaler technique. There was no association between knowledge and course stream, or clinical experience, although personal experience of asthma did seem to be significantly associated with knowledge.
Conclusion: Medical students lack adequate knowledge and experience in paediatric asthma management. A review of the medical curriculum is recommended.
Chronic rhinosinusitis (CRS) is a common and debilitating disorder affecting 10% of the population and leading to frequent attendance in Primary Care. Nasal symptoms, facial pain and associated systemic malaise lead to significant impairment in quality of life and productivity; CRS has been identified as one of the top ten most costly diseases for employers. Despite this management is often sub-optimal.

The aims of the study were to identify associated medical and psychiatric co-morbidities and quality of life issues amongst those with CRS compared with healthy controls and to explore the experience of CRS from the perspective of sufferers.

A self-reported questionnaire distributed from 30 ENT clinics across the UK, including study-specific questions about past medical history and allergies, QoL tools and qualitative interviews with patients.

A total of 1,470 questionnaire participants, age range 18-102 years, including 221 controls. Qualitative interviews were undertaken with 21 CRS patients.

CRS was significantly associated with asthma and inhaled allergies. Sufferers reported that their upper and lower airways symptoms were closely related, but treated separately which was detrimental.

Highly significant differences were seen in generic and disease-specific QoL between cases and controls, with cases having less favourable scores. QoL issues were very important to sufferers, and had been poorly addressed, particularly with regards to loss of sense of smell. Smokers with CRS were particularly negatively impacted.

Medication use “despite good evidence based guidelines for their first-line use, less than 20% of those diagnosed reported use of intranasal-corticosteroids.

This study highlights the impact of CRS, the importance of treating CRS in a similar manner to other chronic conditions including management of associated QoL issues. Upper and lower airways disease should be managed in tandem. Guideline directed management should be emphasized with particular reference to correct use of INCS along with smoking cessation.
29. Using “Active Signposting” to streamline General Practitioner workload in two London based practices

Faisal Siddiqui, Baljinder Sidhu, Aumran Tahir.

General practice is at the forefront of the NHS but is currently being overwhelmed by ever-increasing patient demand and financial constraints. Telephone consultations (TCs) have been used as a method to ease pressure on general practice. Many of these consultations are booked with general practitioners (GPs), despite occasions when the patient could have either been signposted to self help or offered an alternative service.

This QIP aimed to evaluate the nature of TCs undertaken by GPs at our two practices; and whether the patients’ needs could have adequately been met without the involvement of a GP. The aim was to introduce an intervention to ensure that at least 70% of TCs were essential.

A retrospective analysis was undertaken to establish a baseline figure for the proportion of essential telephone consultations in two practices. A new intervention was introduced, prompting reception staff to actively signpost any avoidable TCs to an alternative service where possible. Two PDSA cycles were completed, and a further post-intervention data analysis was undertaken.

Two practices were involved in the study. After 2 PDSA cycles, the proportion of essential consultations taking place at both practices increased from 28.6% and 27.3% at baseline, to 82.6% and 71.4% respectively.

A lower number of possibly avoidable TCs equates to more time for essential TCs and greater value for money for the practice. Applying these results to general practice as a whole, patient access to care is also improved, with patients directed to alternative and often quicker services which still meet their needs adequately. With the current system of primary care unable to cope with the demands it faces, interventions such as active signposting provide value for both GP practices and patients alike.
30. Operational Failures and Interruptions in General Practice: Protocol for a Systematic Review

Dr John J Park, Dr Alexandros Georgiadis, Dr Rebecca Simmons, Professor Mary Dixon-Woods, Dr Carol Sinnott

General Practitioners (GPs) in the United Kingdom are experiencing substantial increases in patient-facing clinical workload, concurrent with greater complexity of work. In contrast with secondary care settings, neither the task-distribution of GPs’ work nor the system-level operational failures (e.g. problems in the supply of information, equipment or materials) that frustrate their work have been clearly characterised. A sound description of the nature and distribution of operational failures is needed to identify targets for intervention.

We aim to systematically review and synthesize the existing literature on 1) the task-distribution of GP work and 2) operational failures in primary care. We will search for observational, experimental and qualitative studies that examine the task-distribution of GPs work or operational failures that disrupt GPs work. We will search seven databases (PubMed, Embase, PsychINFO, CINAHL, Health Business Elite, British Nursing Index, Healthcare Management Information Consortium) for articles published in English from inception until October 2017. One author will review titles and/or abstracts for all retrieved citations. Two authors will screen full texts of potentially relevant citations, extract data and perform risk-of-bias assessment independently. We will conduct a narrative synthesis (including text and quantitative data) of included studies. We have developed a search strategy in collaboration with a medical librarian. After removal of duplicates, the initial search has retrieved 6,963 citations and screening is underway. Before synthesis, we will separate papers into two sets; one on-task-distribution, which is necessary to put operational failures into context, and the other on the nature and distribution of operational failures in primary care.

This study will be the first to synthesize the existing literature on the task-distribution of GPs and operational failures in primary care. This information is needed to highlight gaps in the evidence, and direct future research on operational failures in primary care.
Health has been defined as the ability to adapt and self-manage (1) and this is also relevant in organisational contexts. Medical schools nationally are rethinking curriculum design in response to external drivers, including changing patient demographics, emphasis on primary care, shifting teaching to community settings, digital revolution, patient empowerment, student empowerment and the need for universities to be socially accountable. Successful academic departments will operate as learning organisations, navigating these drivers, opportunities and challenges, supporting staff to develop evidence-based, innovative curricula while in turn contributing to the evidence base. Wenger coined the term Communities of Practice to describe groups of people who share a concern or passion for something they do and learn how to do it better as they interact regularly and described the three dimensions of communities of practice as joint enterprise, mutual engagement and shared repertoire (2). We have drawn on Wenger’s work to develop our own departmental educational Communities of Practice (eCoPs).

To design an eCoP model as a mechanism for managing change. We drew on Wenger’s three dimensions of Communities of Practice as a framework to inform design of our eCoP model. We reviewed drivers in medical education to identify themes for eCoPs to focus on. For year 1 of this project, these rotate through student and patient voice, pedagogical innovation, professional development and digital learning. eCoP members consider their teaching and research projects in light of these themes to support evidence-based innovation. We will present our eCoP model and plans for evaluation, outlining how it relates to Wenger’s dimensions of Communities of Practice, and the structure and process by which eCoPs operate, including strategies to promote creativity and innovation. This eCoP model offers an approach to change management in medical education, potentially transferrable to other organisational settings seeking to develop as learning organisations.
32. Walking a tightrope: GP attitudes to deprescribing anti-hypertensives in multimorbid older patients

Fiona Scheibl, Carol Sinnott, Rupert Payne

In the UK, over half of those aged >80 years are prescribed two or more antihypertensive medications. 1 Studies of patients’ attitudes towards hypertension treatment suggest there is dislike of medication and its side effects, fear of the long-term impact of taking medication, and consequent intentional non-adherence to treatment. 2 Clinicians may struggle to stop prescribing medication due to a perceived lack of evidence, fear of the reaction of other prescribers, and concern that patients will feel their care is being cut. A detailed exploration of UK GP’s experiences of deprescribing antihypertensives has yet to be conducted.

To explore GP perspectives on the barriers and facilitators to reducing antihypertensive medications in older patients (aged >80 years).

Face-to-face interviews with GPs. We used chart-stimulated recall to explore factors which influence GP treatment choices in older multimorbid hypertensive patients, drawing on anonymised records from patients aged >80 on two or more antihypertensive medications. We analysed interview transcripts using a thematic approach. Core themes were refined at a multi-disciplinary analysis workshop attended by GPs, cardiovascular physicians, and a patient representative.

We have completed 13 GP interviews to date. Initial findings show that many GPs take an individualized approach to treatment decisions in patients >80 years, albeit with varying regard for clinical guidelines and targets. For many (but not all) GPs, de-prescribing was primarily considered following a trigger, including falls, patient reported side effects, and terminal illness. Many barriers to de-prescribing were identified, including a lack of time and resources, uncertainty as to how to de-prescribe, and perceived demands from patients and carers for treatment.

GPs describe multiple challenges in proactively de-prescribing antihypertensives for older people with complex multi-morbidities, in spite of increasing evidence of the potential harms of polypharmacy.
33. How primary care could better meet the needs of stroke survivors with returning to work: focus groups with stakeholders from a local UK community.

Chantal Balasooriya-Smeekens, Andrew Bateman, Jonathan Mant, Anna De Simoni.

Many stroke survivors of working age want to return to work, but encounter difficulties. Existing research does not give us clear cut answers as to how primary care can best enable people with stroke going back to work.

Exploring the role of Primary Care in better supporting TIA/stroke survivors returning to work, gathering views from all stakeholders in a local community. Qualitative study using framework analysis of four focus groups held in Cambridgeshire with TIA/stroke survivors, carers, employer representatives, GPs, Occupational Therapists (OTs) and clinical commissioners.

Despite GPs widely recognising that return to work after stroke has positive effects on health, the role of primary care was perceived to be limited. Clinicians were unaware of the effects of invisible impairments like fatigue and cognitive problems, and of ways to effectively support patients’ returning and staying in work. Patients described that work adjustments were more straightforward for physical than invisible impairments; that large organisations provided more structured return to work support and that local neurorehabilitation services were of great benefit. However, GPs were largely unaware of the option of referral to neurorehabilitation services, which was mainly through secondary care. Neurorehabilitation services capacity is limited, though, and commissioning such services was seen as a major challenge, requiring strong evidence of cost-benefit. All stakeholders welcomed greater involvement of primary care. Suggestions for improvement included: (1) a central person (nurse) in primary care as point of contact regarding work-related issues and referral to available services; (2) a rehabilitation assessment integrated with the electronic GP record, easily accessible by GPs and highlighting invisible impairments; (3) a patient-held shared-care plan at discharge from stroke wards.

Primary care has the potential to support stroke survivors successfully returning to work, and address inequalities in access to vocational rehabilitation support.
Quality Improvement projects (QIPs) are now integral to Junior doctor training programmes. This London Medical School introduced a QIP for students in their penultimate year for their core curriculum. Students in small groups (2-5) were allocated a supervisor and 9 projects were in GP settings for 9% of the cohort (N=35). This new ambitious programme was piloted but the final plans changed in terms of assessment requirements, supervisor preparation and access to the virtual learning environment (VLE). In depth evaluation was undertaken at the end of the academic year. The evaluation aimed to explore the students views and experiences of the GP QIPs, what opportunities this provided for experiential learning in this clinical context. In addition, the evaluation explored the views of the GP supervisors and the sustainability of this teaching. A mixed method evaluation, to ascertain the type of QIPs done, the number of PDSA cycles and the feasibility and sustainability of this from both GPs and students perspectives, was conducted. The QIPs were related to disease prevention; health promotion; efficiencies.

Eight of the nine projects managed one complete PDSA cycle. Both students and GPs felt the preparation was suboptimal but over the weeks became more confident. All participants valued the QIP opportunity and the sense of contributing and learning simultaneously, with GP supervisors reporting the value of the QIP to the practice. This was, however, challenging, with insufficient time allocated for teaching and assessment.

The planned time was reduced from 20 weeks to 15 weeks, more preparation and support is needed face to face sessions to complement virtual learning requirements. That said, the QIP component and opportunity was valued and modifications have been made to improve the module.
35. Statins therapy after stroke in the UK general practices, 2000-2014: a retrospective cohort study using the Clinical Practice Research Datalink

Zhirong Yang, Duncan Edwards, Jonathan Mant.

The benefits of statins for ischaemic stroke have been demonstrated and recent clinical guidelines recommend high intensity of statins for this disease. However, limited data are available regarding the use of statins and intensity among these patients in real practice.

To examine trends and factors of statin prescription and high-intensity statin use following first stroke.

A retrospective cohort study of patients with first stroke between 2000 and 2014 was conducted using the Clinical Practice Research Datalink, with haemorrhagic stroke excluded. Proportions of statins users and high-intensity statins users were estimated for each calendar year. Cox regression model was used to explore potential factors associated with statins use and high-intensity statins use.

80,442 patients with first stroke were included. The proportion of patients using statins increased rapidly from 25% in 2000 to 70% in 2006, before further rising to about 75% in 2014. Among statins users, high-intensity users accounted for about 15% between 2004 and 2011 and then increased to almost 40% in 2014. Statins underuse was independently associated with younger age (18-44 years), older age (75-84 and >85 years), atrial fibrillation, chronic liver diseases, dementia, heart failure, underweight, absence of cardiovascular factors (coronary heart disease, chronic kidney diseases, diabetes, hypertension, smoking, and obesity). Moreover, younger age, older age, and absence of cardiovascular factors were associated with underuse of high-intensity statins.

After a rapid increase in statins use following stroke, since 2006 the proportion of patients on statin treatment remained at a high level. The use of high intensity statins was increasing from 2011 through 2014. We identified several factors highly associated with the reduced use of statins, most of which were also associated with underuse of high-intensity statins. Evidence-based statins treatment was suboptimal in these patient groups, which has significant implications for both clinical practice and future research.
It has been suggested that interactions between patients and practitioners in primary care have the potential to delay progression of complications in type 2 diabetes. However, as primary care faces greater pressures, patient experiences of patient-practitioner interactions might be changing. We aim to explore the views of patients with type 2 diabetes on factors that are of significance to them in patient-practitioner interactions after diagnosis, and over the last ten years of living with the disease.

A longitudinal qualitative analysis in UK primary care. The study was part of a qualitative and quantitative examination of patient experience within the existing ADDITION-Cambridge and ADDITION-Plus trials from 2002 to 2016. We conducted a qualitative descriptive analysis of free text comments to an open-ended question within the CARE measure questionnaire at one and ten years after diagnosis with diabetes. We analysed data cross-sectionally at each time point, and at an individual level moving both backwards and forwards between time points to describe emergent topics.

311 (28%) and 101 (27%) participants commented at 1 year follow-up and 10 year follow-up respectively. 46 participants commented at both times. Comments on preferences for more time with practitioners, face to face contact and relational continuity of care were more common over time.

Our study highlights issues related to the wider context of interactions between patients and practitioners in the health care system over the last ten years since diagnosis with diabetes. Paradoxically, these same aspects of care that are valued over time from diagnosis, are also increasingly unprotected in UK primary care.
Women using combined hormonal contraceptives (CHC) have an increased risk of venous thromboembolism. Despite the risks, in 2013, the European Medicines Agency (EMA) concluded that overall the likelihood of venous thromboembolism is small and that the benefits of CHC outweigh their disadvantages. A report published in 2014 by the European Commission revealed that 6 out of 10 people go online when looking for health information. More specifically, they found that 8 out of 10 individuals aged between 15-39 tend to search for health information on the internet. However, little is known about the online information sources which are available for women to search for information about CHC, and whether these sources refer to the risks of CHC, and if so how this is expressed.

The internet is used primarily by younger people to seek information about health so we sought to conduct an internet search to explore websites across 6 European counties providing information about CHC, including the risks.

We conducted an internet search across six different countries (Denmark, Germany, Netherlands, Slovakia, Spain and the UK), using the Google search engine. We followed a systematic search procedure, using the search terms combined hormonal contraceptives, women health professionals, venous thromboembolism and risks, including relevant synonyms. We were mainly interested in websites published after 2013, to explore whether the websites reflected the EMA 2013 recommendation.

We found 357 websites across the six countries. The majority were provided by non-governmental medical association/services and the media. Most websites included general information about CHC (e.g. how to take them, how do CHC work, what to do when pills are missed) and the risks of CHC, including venous thromboembolism. Nearly fourth quarter of the websites guided women I relation to which CHC they should use. A small minority of websites provided visitors with the opportunity to engage in discussions or ask questions and referred to the EMA regulations.

These results indicate that online resources about CHC tend to inform readers about the risks of these medicines, even though most of them do not mention the recommendations of EMA. The accuracy and consistency of the information provided by media websites needs further attention. Future work should also focus on understanding if and how women tend to use internet resources and how do they impact on their decisions about CHCs.
Patients can be reluctant to say that they need help and support, telling clinicians they are “fine” despite having unmet needs. Research with patients in mental health settings suggests that when patients do this they are less likely to follow treatment plans, and their informal carers may be at a risk of depression. To date these findings have not been explored in patients with advancing physical health conditions or their carers.

To explore the presence and role of “I’m fine” or equivalent assertions for patients with advanced chronic obstructive pulmonary disease (COPD) and their carers; and to examine the impact denials of support needs may have on their health and service-use.

21 patients and six carers asserted they were “I’m fine” despite unmet needs. Patients’ minimised the effects and symptoms of their advanced COPD, avoided thinking about the future and used stoical language in an attempt to downplay negative experiences. Despite “I’m fine” cases being more likely to report no exacerbations and more likely to score less on the COPD Assessment Test (CAT), all reported a desire to see more of their GP. Carers focused on the needs of the patient whilst downplaying their own problems or distress.

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The existence of a sub-group of patients with advanced COPD who assert that they are “fine” may have implications for clinical practice. Planned focus groups with health care professionals will be used to consider the above findings within the context of primary care.
39. Undergraduate education in primary care- the literature behind the Wass report (Plenary)

*Melvyn Jones, Maslah Amin, Shiv Chande,*

The NHS needs a successful primary care system to continue to function but has struggled to recruit the necessary workforce. Health Education England (HEE) have been mandated to ensure that 50% of foundation doctor enter GP training programmes in order to meet projected demand. The NHS HEE Wass Report among its various recommendations to boost GP numbers, highlighted the importance of undergraduates’ (UG) GP experience as an influence on their choice of career specialty.

To explore what is known about UG influences on a GP career choice.

NHS HEE employed two junior doctors (MA and SC) to produce a rapid narrative review of the published literature on the UG influences on GP career choice for the Wass Report. The search strategy was supported by medical librarians and focused on rapidly accessing and summarising relevant literature. The searches of databases (Medline, EMBASE, Health Management Information Consortium [HMIC]) and grey literature in 2015 revealed 298 items. Data extraction and synthesis was pragmatic.

The international evidence shows that students who had more UG GP placements are more likely to become GPs. The style of UG placements is also important, with longitudinal placements being more influential. The UK literature in this area is limited, but there are some consistencies with the international evidence. The analyses highlight key elements of placements and compare longitudinal placements with traditional block placements.

The implications of these results for medical school curricula will be discussed with particular reference to Government plans to expand medical student numbers and establish new medical schools with explicit aims to produce more GPs and psychiatrists. The strengths and weaknesses of this pragmatic approach will be discussed.
40. An exploration of the disease phenotype of patients prescribed oral anticoagulation within CPRD but who have no relevant medical diagnosis recorded.

Erin Weatherstone, Jenny Lund, Duncan Edwards

Routinely collected primary care data is increasingly being used for research purposes. To make this data useable it is important to accurately phenotype medical conditions within it. This research explores patients who have a record of anticoagulation but no recorded relevant diagnosis and investigates what can be deduced from these patients.

Previous research assumed a diagnosis of atrial fibrillation (AF) if there was a record of a warfarin prescription, but is this the correct assumption?

A random sample of 12,535 patients aged over 65 who had one or more prescriptions for oral anticoagulation was used. Relevant diagnosis codes were identified for AF and other anti-coagulable cardiac conditions, thromboembolic events and total joint replacements. Following this 1,138 (9.08%, 95% CI 8.6:9.6%) patients were identified who were prescribed an oral anticoagulant but had no relevant diagnosis. A further descriptive analysis was undertaken of these patients.

11,397 patients had an identified diagnosis, 31% (95% CI 29.7:31.4%) of these did not have a diagnosis of AF. Of the 1,138 patients with no diagnosis 4.5% (95% CI 3.4:5.8%) had a CHADSVASC2 score indicating possible AF and 37% (95% CI 34.1:39.7%) had a duration of anticoagulation less than 6 months indicating possible anticoagulation for reasons other than AF.

Routine clinical data is increasingly used for research, with variables and outcomes such as the diagnosis of AF constructed using assumptions which should be questioned. Caution should be made to look at other factors before making an assumption of a diagnosis of AF based on prescription of anticoagulation.

In addition anticoagulants are highly effective and harmful medications requiring close monitoring. Practices should consider an audit of patients prescribed oral anticoagulation to ensure all have a relevant recorded diagnosis.
41. Why do GP trainees apply for General Practice training: The mismatch of expectation and reality?

Dr Sophie Williams, Dr Russell Hearn.

There is current shortage of applicants across the United Kingdom to the General Practice training schemes and a high level of attrition from completion of training to taking up posts in some areas. Currently there are many initiatives to incentivise medical students and junior doctors to apply for the specialty, but what is really important to our London Trainees?

To explore the factors that incentivised current GP trainees to apply to the General Practice scheme, and how their hopes in apply match reality. This may then inform future innovation to improve recruitment and retention.

A focus group of trainees on a London General Practice Speciality Training programme was conducted using a topic guide informed by a group survey. This sought to explore trainees’ reasons for applying for General Practice and how their experience of GP training so far has aligned with these reasons. The group was audio recorded, transcribed anonymously verbatim and thematic analysis was undertaken.

Decisions to apply for GP training are complex and multifactorial. In addition the hopes of those applying do not always match with reality. Trainees cited the standing of the profession of GP within the psychosocial vocational landscape as a barrier to applying, with work-life balance and continuity of care as positives. The reality of training has a distinct lack of continuity within the current NHS and changes to contracts have destabilised the vocation towards being a GP.

The findings support some ongoing transformation and innovation projects for undergraduate and postgraduates who are currently undecided on their specialty. The motivations of current GP trainees seems to differ to the motivations of fully qualified and established GPs. A stronger approach to improving soft benefits of being a GP may well improve recruitment and retention.
42. Integrated care: learning from East London

Sonia Bussu, Martin Marshall

Despite a growing body of literature on integrated (e.g. Curry and Ham, 2010; Lewis et. al., 2010; Shaw et al., 2011; Humphries and Curry, 2011; Burns and Pauly, 2012; Humphries, et al., 2012; Ling, et al., 2012; Roland, et al., 2012; Bardsley, et al., 2013; Curry, et al., 2013; Evans, et al., 2013; Lewis, et al., 2013; Shortell, et al., 2014), there remains a relatively small evidence base to suggest which elements of integrated care are most effective and how to implement them successfully. This might also be due to the fact that policy thinking around integrated care is struggling to translate into organisation change at the point of delivery. Better understanding of patterns of collaborations and integrated pathways is crucial to understand frontline staff’s OD needs and provide adequate support.

This paper focuses on the frontline level to assess progress towards integrated care in East London, following the implementation of the Waltham Forest and East London Pioneer Programme of Integrated Care (WEL). We use admission avoidance and discharge services as a lens to examine how frontline staff from secondary care, community health services and social service work together to deliver more integrated care across the WEL footprint.

The study uses the Researcher in Residence (RiR), where researcher is embedded in the in the organisations she is evaluating, as a key member of the delivery team, as opposed to an external observer of change. The aim is to enable co-creation of knowledge between researchers and practitioners, with the aim to increase opportunities for evidence to influence programme development. Research expertise is communicated to and negotiated with, rather than imposed on, the practitioners in the delivery team and other stakeholders.

Initial findings suggest that while the work on integrated care has enabled some level of collaborative working at strategic levels in partner organisations, on the frontline professionals are grappling with issues such as professional identity, professional boundaries, mutual trust and accountability, as new teams and roles struggle to be fully embedded within the local health system. A plethora of policy initiatives has resulted in continual reconfiguration of community health services without enough thinking about potential overlapping between the functions of new teams and pre-existing ones, while underfunding of social services inevitably undermines efforts at integrated care.

The paper sheds some light on to the complexity on integrated care at the point of the delivery and looks at new roles and services (i.e. discharge to assess; rapid response) that can potentially play a crucial role in driving greater care coordination between acute, community health services and social services. However, better understanding of integrated care pathways is crucial to:

- evidence patterns of collaboration across organisations;
- assess how these new roles and teams are embedding themselves within the local health economy;
- identify organisation development needs;
- provide adequate support to frontline staff.
43. Coding and CKD risk factor management in hypertensive patients in primary care

Grace Okoli, Mark Ashworth, Stevo Durbaba, Mariam Molokhia.

Chronic Kidney Disease (CKD) affects approximately 6% of adults in the UK[1], increasing due to associated comorbidities such as hypertension, diabetes and age. Most patients with CKD are identified and managed in primary care, supported by Quality and Outcomes Framework (QOF) incentives which were first introduced into the QOF in 2006, and recently revised in 2016[2]. QOF indicators are based on CKD NICE guidance and used to assess risk management in these patients to help determine the effectiveness of CKD management in primary care[3,4].
To examine risk factor management in hypertensive patients with QOF coded and uncoded CKD 3-5 in primary care.

We examined EHRs from 44 Lambeth practices with a total of 286,162 patients, in SE London (Lambeth DataNet, 2013). For CKD 3-5 classification in hypertensive patients, we compared risk management in QOF (READ) coded patients with patients where coding was absent â€œuncoded CKD 3-5, using MDRD eGFR equation with ethnicity correction (eGFR < 60mls/min/1.73m2). We found 73% of hypertensive patients with CKD3-5 were coded (n= 4655/6380). When stratified by age; we found significant differences in proportions between coded and uncoded CKD3-5 for statin use (p<0.0001 in under 75’s; p=0.0002 in over 75’s); and ACEI or ARB use (p<0.0001 in under 75’s; p=0.014 in over 75’s).
For all CKD hypertensive patients, age, gender and ethnicity adjusted OR (95% CI) for coded versus uncoded patients were: use of statins 1.47 (1.29-1.67), ACEI or ARB medications 1.27 (1.12-1.44), systolic BP control 1.17 (1.02-1.34), and African 1.62 (1.32-1.99) or Afro-Caribbean ethnicity 2.74 (2.27-3.30).

Our findings suggest suboptimal risk factor management in uncoded patients with CKD, which may reflect poorer quality of care. Patients with uncoded CKD have potentially higher risks for hypertensive disease, and lower uptake of statins and ACEI/ARB medications which could be improved.
44. Comparison of self-reported physical activity with objective accelerometry from the PACE-Lift trial in older adults in a primary care setting

Dr Shaleen Ahmad, Tess Harris, Derek Cook

Comparison of self-reported physical activity with objective accelerometry from the PACE-Lift trial in older adults in a primary care setting

Increasing physical activity (PA) in older adults has well-recognised health benefits and is an important public health focus. We compared objective accelerometry with self-report PA data in 60-75 year old PACE-Lift trial participants.

To compare objective accelerometry with self-report PA data in 60-75 year old PACE-Lift trial participants and to assess the construct validity of accelerometry and self-report PA questionnaires. Objective accelerometry and self-report short International Physical Activity Questionnaire (IPAQ) trial data at baseline, 3 and 12 months were analysed (control n=148, intervention n=150). The main statistical analyses consisted of: i) Comparing change in PA based on IPAQ with accelerometry; ii) Assessing construct validity of accelerometry and IPAQ against known PA predictors in older adults. 3-month accelerometry showed a significant difference for increase in both daily steps (1041, 95% CI 519-1563, p<0.001) and weekly minutes of moderate to vigorous physical activity (MVPA) (63, 95% CI 40-86, p<0.001) between control and intervention groups. This treatment effect was still evident at 12-months. No treatment effects were seen for IPAQ data.

Factors associated with change in MVPA from IPAQ included only gender (male 169; 67 to 271), pain (moderate/extreme -192; -257 to -27) and depression score (high -233; -439 to -27). Change in accelerometry steps was associated with many variables: age (70-75y -1215; -2062 to -368), general health (fair -1528; -2632 to -423), chronic disease score (3+ diseases -1658; -2888 to -429), disability score (moderate to severe -2475; -4556 to -393), longstanding illness (limiting illness -896; -1656 to -137), pain (moderate/extreme -1322; -2352 to -292), depression score (high -2365; -3641 to -1089), self-efficacy (high 1060; 262 to 1858), brisk walking pace 2618;1341 to 3895) and BMI (obese -1556; -2398 to -714).

The increase in PA outcome measures by accelerometry were not shown by the short IPAQ. Accelerometry showed much stronger construct validity than the short IPAQ. Objective accelerometry is a better measure of PA change for use in trials, compared to self-report short IPAQ.
45. Opportunistic pulse checks in primary care to improve recognition of atrial fibrillation.

Jim Cole, Payam Torabi, John Robson.

Atrial fibrillation (AF) is an important and modifiable risk factor for stroke. Earlier identification may reduce stroke-related morbidity and mortality. Trial evidence shows opportunistic pulse regularity checks in people aged 65 years or more increases detection of AF, however, this is not currently recommended by the National Screening Programme nor implemented by most Clinical Commissioning Groups (CCGs).

To evaluate the impact of a systematic programme to promote pulse regularity checks in general practice on their uptake and the prevalence of AF.

Retrospective analysis of electronic primary care patient records in three east London CCGs (City and Hackney, Newham and Tower Hamlets) over 10 years. Rates of pulse regularity checks and prevalence of AF in people aged 65 years or more were compared for the pre-intervention period 2007-2011 to post-intervention 2012-2017.

Across the three CCGs, rates of pulse regularity checks increased from a mean of 7.3% pre-intervention to 66.4% post-intervention, achieving 93.1% in the final year. Age-standardised prevalence of AF in people aged 65 years or more increased significantly from a pre-intervention mean of 61.4/1000 to a post-intervention mean of 64.5/1000. There was a significant increase in post-intervention trend to a final year mean of 67.3/1000; an improvement of 9.6% (5.9/1000) with 790 additional new cases identified.

Organisational alignment, standardised data entry, peer performance dashboards and financial incentivisation rapidly and generally increased opportunistic screening with pulse regularity checks. This was associated with a significant increase in AF prevalence of public health importance.
46. Electronic Clinical Reasoning Skills Educational Simulation Tool (eCREST): using online simulations to teach medical students clinical reasoning applied to tasks faced in primary care

Jessica Sheringham, Angelos Kassianos

Clinical reasoning describes the thought processes required to identify likely diagnoses, formulate appropriate questions and reach decisions during patient consultations. Flaws in clinical reasoning are important causes of diagnostic errors amongst qualified doctors. It is therefore recommended that medical education includes clinical reasoning skills teaching.

Online patient simulations enable students to practise such skills in a safe environment. However, there are gaps in our understanding of optimal designs, impacts on learning and effective application to clinical reasoning tasks faced in primary care.

We sought to develop and evaluate theory-informed online simulations to teach clinical reasoning in medical schools, applied to the diagnosis and management of common respiratory symptoms in primary care.

eCREST (electronic Clinical Reasoning Skills Educational Simulation Tool) seeks to address cognitive biases which can impair clinical reasoning. Interactive “patient” simulated cases were developed where students “ask” “patients” questions to form their differential diagnosis and receive responses as videos of patient-actors or text giving test results and previous consultation notes. Informed by experiential learning theory and iterative hypothesis testing, it prompts students to explain the information elicited about patients and their diagnostic hypotheses. Students also complete a knowledge quiz and reflective questions.

In 2016/17, a feasibility trial in two medical schools measured participation and self-reported learning.

84 final-year students registered for eCREST, of which 46 (55%) completed all cases. Of those, 65% agreed it helped them learn clinical reasoning applicable to clinical work. Students also reported they formed new strategies for asking questions and considered more differential diagnoses than previously.

Early evaluation suggests eCREST was acceptable and might improve clinical reasoning in medical students that ultimately could reduce diagnostic errors in primary care. It also provided methodological insights into evaluating such approaches. In 2017/2018, a further trial in three medical schools will assess changes in clinical reasoning.
47. Analysis of reason for encounter and potentially avoidable encounters a snapshot of an inner city GP practice in East London

Aysha Gomaa, Dr. Thomas Round.

Primary care is the first point of call for most patients experiencing health problems, though it is facing a workforce and workload crisis. It is therefore essential to gain further insight into reasons for encounter (RFE) and identify any potentially avoidable encounters (PAE).

The aims of this audit were to identify RFE, the outcomes of these consultations and to recognise PAE at an inner city practice in East London.

A random number generator was used to pick four days corresponding with each season to give a snapshot of activity. Based on the clinical notes and read codes, encounters were coded using the ICPC-2 classification. A judgement was then made as to whether the appointment was potentially avoidable.

Over 6400 patients are registered at the practice. A total of 439 appointments were booked on the four days and 346 (78.8%) were included in the audit. The 93 excluded encounters include phlebotomy appointments (15.5%) and unattended appointments (5.7%). 78.6% of patients were seen by GPs, 15% by nurses and 6.1% by healthcare assistants. The top three RFE systems were skin (14.4%), respiratory (14%) and musculoskeletal (12.3%). Almost 25% of outcomes were medication related and 20% were patient education. Up to a third of appointments were PAE and the categories correspond to the top three RFE. 47% of PAE could have been seen by a different healthcare professional (HCP), and 35% could be managed through self-care. The remainder were admin related or ones which could be managed in the community.

Identifying the main RFE and PAE in primary care is important in the redesign of services, including triage and redirecting patients to other HCPs. Strategies to reduce unattended appointments could increase booking capacity. Facilitating patients to take an active role in their health could promote self-care and reduce the number of PAE.
48. Polypharmacy in Pakistani patients: A qualitative study

Najia Sultan, Deborah Swinglehurst

Polypharmacy is the co-prescription of four or more medications. The patient experience and possible burden of being on multiple medications is poorly understood. Up to half of all medications prescribed are never taken and medicines wastage in the NHS is estimated to cost £150 million a year. High-quality knowledge to inform prescribing and de-prescribing in multimorbidity is needed. London’s South Asian population, including those of Pakistani origin, are known to be on the receiving ends of higher levels of prescribing compared to other ethnicities. Urdu is the third most common spoken immigrant language in England and Wales and Urdu speaking Pakistani patients form a significant ethnic group in London. Given the lack of research in this patient group, culturally sensitive knowledge is needed to inform person-centered prescribing practices for this population. To explore the experience of polypharmacy in Pakistani patients with multimorbidity to establish:

- What is the patient experience of polypharmacy in multimorbidity?
- How do patients manage their medicines in the context of their daily lives?
- How do patients describe their relationships with professionals involved in their medicines management?

12-15 patients will be recruited from GP practices in East London. Patients will complete an in-depth narrative interview with a bilingual researcher in Urdu at home. For inclusion, patients must be of Pakistani origin, aged 50 + and be on 10 of more regular medications (this is a strategy for identifying “high risk” polypharmacy).

The study is currently recruiting patients.

The presentation will explore the context and need to better understand Pakistani patients “lived experience” of polypharmacy. It will explore the challenges of accessing these patients and the use of narrative methods cross-language. This is a population that is under-researched and over-represented in terms of polypharmacy and multimorbidity. The research will provide new knowledge that can inform professional practices and improve care.
49. Managing malnutrition in later life: exploring the views and dietary practices of older people at risk of malnutrition and their carers

_Cini Bhanu._

Malnutrition is a significant cause of morbidity and mortality in older people and 1.3 million people over 65 in the UK suffer from malnutrition. Malnourished people see their GP twice as often as those who are nourished. However, malnutrition is commonly under-recognised in general practice due to limitations in consultation time and lack of training. There is little evidence on the views of community-dwelling older people and their carers on how malnutrition is managed and what support they consider desirable or acceptable.

1. To explore the views and dietary practices of older people at risk of malnutrition and their carers
2. To identify gaps in knowledge, barriers and facilitators to healthy eating in later life.
3. To explore potential primary care interventions for malnutrition in later life

Semi-structured interviews will be conducted with community-dwelling people aged â‰¥75 years from up to four general practices in urban and suburban areas, identified as malnourished/at risk of malnutrition. Carers supporting them with meal preparation will also be invited. Data collection will continue until saturation of key themes. Interviews will be audio-recorded and transcribed verbatim. Thematic analysis will be used to identify key emergent themes and their meaning, with input from the entire research team including lay members.

In progress, results to follow

The views of older people and carers contribute to a programme of work on malnutrition in frail older adults. Together with findings from a systematic review on nutritional education delivered in primary care and the views of community and primary care professionals, we aim to develop an acceptable and feasible intervention for frail older adults with malnutrition. Findings have clinical relevance as the 2017/2018 GP contract requires identification of people with moderate-severe frailty, but the evidence base on how to support them to improve outcomes is weak, particularly for nutritional interventions.
50. Patient experiences of referral to neurologists for imaging, versus GP direct access to MRI for headache

Alison McKinlay, Raphael Underwood, Asif Mazumder, Rachael Kilner and Leone Ridsdale

Patient experiences of referral to neurologists for imaging, versus GP direct access to MRI for headache

For many people who experience headache (HA), symptoms can be self-managed. Nevertheless HA is the commonest neurological symptom presented to GPs, and the commonest reason for referral to a neurologist. Most people referred want imaging and because of this, access to MRI is being made available directly through GPs. At present, little is known about patient experiences of the direct access imaging pathway compared with referral to a neurologist. In this study, we aimed to compare user experiences of the direct access and neurology pathway in London.

We developed an interview schedule with questions about patient experiences of referral to a neurologist and imaging versus direct access to imaging via their GP. Interviews were scheduled a minimum of two months after the initial scan, and ranged from 28-117 minutes. Sessions were audio recorded and transcribed, then analysed using thematic analysis in Nvivo.

We interviewed 20 patients in South London, UK. There were nine men, eleven women, median age 41, range 20-72.

Sixteen out of twenty participants had received their scan results by the time of interview; four participants in the direct access pathway group had not received their results. Two of the four participants were worried about the delayed results, one participant was trying alternative treatments, and one had an improvement in symptoms.

Fourteen participants described feeling relief, from feeling their concerns were listened to, and having an answer about the underlying cause of their HA. Thirteen participants described experiences of uncertainty and concern regarding their referral, relating to scan anxiety, health anxiety, patient wait times (for an appointment and for results), and lack of answers or reassurance after the scan.

Twelve participants felt they received a clear and logical explanation from their healthcare services. Eight participants experienced difficulty with communication (i.e., medical jargon in results, unclear results explanation) during the referral process.

The primary finding of this study is that lack of communication of imaging results were a prominent source of uncertainty and concern. Our results show relief and uncertainty at different stages throughout both referral processes, with uncertainty being most closely linked with wait times to see a neurologist or to get results.
51. The General Practice Workforce Crisis: What are sessional GPs really looking for in a workplace?

Dr Susan Willacy, Dr Ellen Wright.

The changing nature of both the work and the GP workforce mean that the traditional model of GP employment may not be as attractive as it once was, and has led to practices struggling to, or being unable to recruit at all. Compounding the workload of those remaining and putting the sustainability of both individual practices and general practice overall in jeopardy.

To understand how current working GPs view the current workforce crisis and its primary contributors.
To look at current practices both well recruiting and poorly recruiting to see if common themes can be identified, and to interview GPs working in these practices to discuss priories in a workplace.
To look at real world solutions which are already in place and see how they could be applicable for those practices struggling to recruit.

This was a mixed methods service evaluation based in one London borough.
It combined paper and electronic surveys to gain an overview general practitioner work patterns and priorities. This was followed up with eight semi-structured interviews to gain a deeper understanding of what the workplace priorities are for those currently working both in salaried and locum positions. Both GPs from practices which recruited well and those which have struggled were interviewed, and a thematic analysis was carried out to try and look for common factors which could lead to targeted interventions to aid recruitment.

The attractiveness of locum roles was felt to be the most significant factor driving GPs from salaried roles. 
The most significant factor for sessional GPs was predictably excess workload. Changes to the basic working day, fewer appointments and allocated time for paperwork were the most frequently suggested solutions. 
Other factors included team ethos and support mechanisms available in the practice, and often demonstrable efforts towards this such as meetings and mentoring were desired.
Financial incentives were ultimately found to have little importance, indicating these funds may be better spent improving other aspects of practice.

The results have implications for practices struggling to recruit or retain staff, and indicate there are effective solutions are already in place in certain practices which are managing to recruit and retain staff. 
The factors desirable for both future and current practices found amongst the sessional GPs were almost universal and they were clear on the changes they felt were needed. These concepts could be used to guide practices into making changes to create a more stable future workforce.
There may be concern around the financial viability of some of these changes, but those practices failing to recruit are well aware of the financial implications of high locum use, and knock on effect for patient care.
52. Promoting diversity in community health care careers: lessons learnt from the WATCCH widening participation work experience project.

Dr Farah Jamil, Dr Sonia Kumar.

The NHS needs more doctors, nurses and allied healthcare professionals as evidenced by the National Audit Office document ‘Managing the Supply of NHS clinical staff in England’ (Feb 2016). The Health Education England document ‘By Choice Not By Chance’ (Nov 2016) highlighted General Practice (GP) as a career with the need for exposure starting as early as primary school. It is more difficult for potential medical school applicants to get work experience in GP practices compared to hospitals, especially from Widening Participation (WP) backgrounds who lack the relevant social connections.

To increase WP pupil’s exposure to a variety of healthcare careers in the community, so they are better equipped to make informed career choices and complete university applications. This would increase their social mobility and importantly increase representation of our diverse population into all healthcare roles.

We placed 20 Year 12 pupils from WP backgrounds in NWL in GP for three days, sandwiched around a pre and post-placement workshop held at Imperial College London over the summer of 2017. Workshops included a multi-professional panel discussing career experiences, creating mind maps and hands on experience in the clinical skills lab. Students were placed in local practices in pairs and according to students’ needs and career desires, individually tailored timetables were planned. During the last workshop focus groups were conducted by researchers not directly connected to the study; these were transcribed and thematically analysed.

Results suggest a deeper understanding of healthcare professions and their realistic challenges. Also the pupils revealed an increased awareness of career pathways, the variety of health care careers on offer and an understanding of their own personal strengths and weaknesses.

Overall the students were very enthusiastic to be a part of a work experience project with interactive workshops, going beyond simple traditional placements. The WATCCH project therefore appeared to simultaneously, raise the pupil’s awareness of the strengths and weaknesses of both themselves and community health care careers leading to more informed decisions regarding their future career choices. The success of WATCCH has led to a doubling of the intake in 2018 to 40 students.
53. Out-of-hours pulmonary rehabilitation classes for workers with COPD: a qualitative evaluation.

Gill Gilworth, Jane Simpson, Claire Davey.

Pulmonary rehabilitation (PR) is the most effective treatment for the symptoms and disability of chronic obstructive pulmonary disease (COPD). (1) The impact of PR is restricted by poor completion rates. (2) GPs have the worst PR completion rates among referrers. (3) COPD has been linked to work disability (premature job loss due to long-term health issues) an outcome that might be improved by early PR referral. (4) PR classes are offered during the working day requiring attendance twice a week. Attendance is challenging for workers. The role of the referrer is of key importance, yet 56% of PR referrers did not refer working patients due to their weekday work commitments. (5) To explore COPD-related job retention and the response of workers offered a PR programme on Saturday mornings.

A focus group was conducted with worker-participants successfully completing Saturday mornings PR, to provide insights into participants' experiences and feelings. One-to-one face-to-face or telephone interviews were conducted with patients offered the course who failed to complete PR. A focus group was conducted with staff members running the out-of-hours PR service. Four patients completing the PR programme took part in the focus group. At the time of writing four patients who failed to complete PR undertook one-to-one interviews. Five staff members undertook a focus group. Thematic analysis of the focus groups and interview transcripts is underway. COPD-related symptoms had a significant impact on work capacity, especially for manual workers. Workers with COPD had great difficulty attending PR during the working week. Access to PR for workers with COPD is severely limited where services are only provided in the working week. COPD patients currently working may have less contact with medical care and may be especially dependent on their GPs to identify the potential of PR to prevent work instability.
54. The challenges of recruiting in local community pharmacy settings

*Sandra Jumbe, Sandra Jumbe, Wai Yee James*

Smokers are four times more likely to quit if they use NHS Stop Smoking Services (SSS). Part of this service is commissioned to local community pharmacies, where pharmacy staff are trained to provide smoking cessation support to smokers. Unfortunately, pharmacy based SSS have recently gone through a mass decommissioning due to low smoker uptake. The Smoking Treatment Optimisation Programme (STOP) aims to address low smoker uptake by training pharmacy staff to provide effective services as part of a cluster randomised trial. The STOP trial involves recruiting 60 pharmacies, and randomising staff from 30 pharmacies to receive the STOP training whilst the others continue to deliver their SSS as usual.

To report on the “Russian doll strategy” for optimising recruitment of community pharmacies to the STOP Trial and engaging pharmacy workers into health research training and activities.

Contacted local commissioners in recruitment areas (London, Coventry and Wales) to introduce the study and get their backing. Commissioners provided updated list of pharmacies providing NHS SSS which STOP team used for recruitment. Some commissioners also emailed their pharmacies to introduce the trial.

STOP Trial manager strategically contacted pharmacy owners/managers about the STOP Trial. Interested owners were encouraged to disseminate trial material to their staff and advise/inform the trial manager about potential participant numbers. The trial team then visited pharmacies for recruitment and individually consent willing staff.

For ongoing trial communication, participating pharmacies were asked to join WhatsApp groups depending on randomisation outcome to receive updates on training dates and trial related issues.

46 out of 60 pharmacies have been successfully recruited in London (29), Coventry (12) and Cwm Taf (5). Recruitment in Coventry and Wales still ongoing, due to complete end of November 2017.

WhatsApp groups have been key as a one stop avenue for disseminating trial related updates to recruited pharmacies and organising pharmacy staff training in the intervention group. 92% attendance rate to the STOP Intervention training by pharmacy staff to date

No pharmacy withdrawals to date

The STOP Trial highlights the challenges involved when recruiting in research naïve health settings like community pharmacies. Strategic breaking through and by in from key stakeholders opens doors for effective pharmacy participation and retention.
55. Costs of providing the Test and Treat chlamydia/gonorrhoea point of care testing service to sexually active further education college students with and without a £10 incentive

Sarah Kerry-Barnard, Charlotte Fleming, Pippa Oakeshott.

Young people attending London FE colleges have high rates of chlamydia and gonorrhoea. Both infections can lead to serious complications including ectopic pregnancy and infertility. But screening rates are low, and young people usually need to attend a healthcare facility to get tested. Immediate cash incentives may be effective in increasing uptake of chlamydia screening in teenagers, but are they cost-effective in terms of disease detection?

Compare the cost of providing incentivised point of care tests (POCT) to non-incentivised POCT. The Test n Treat study included non-incentivised POCT at one and four months after recruitment at three further education colleges, and then a seven month follow up POCT with a £10 cash incentive. Students were invited to all screening opportunities by text message or email, poster advertisement and messages from the staff. For the 7 month incentivised follow up, participants were also invited by telephone call.

The costs of providing the service with and without the incentive will be reported as overall cost; cost per person screened, cost per infection identified and cost per infection treated. Costs include staff costs, machine rental, consumables and treatment. Some students attempted to impose as others or get tested twice.

Cuts in local authorities’ public health budgets have closed sexual health clinics and risk further falls in STI screening rates and higher rates of transmission and complications. Results from this study on the cost effectiveness of Test n Treat could help guide policy. Potential adverse consequences such as altering motivation exogenously with financial incentives and requiring ID to limit gaming of the system require further research.
The burden of chlamydia and gonorrhoea is high in 15-24 year olds but less than 20% are tested annually in England. We conducted a cluster-randomised feasibility trial of rapid chlamydia/gonorrhoea testing and same day on-site treatment (“Test n Treat/TnT”) in six Further Education colleges to assess:

- TnT uptake rates
- Follow-up rates
- Prevalence of chlamydia/gonorrhoea at baseline and 7 months
- Acceptability of TnT

We recruited 509 sexually active students, median age 17.9 years, 47% male, 50% black ethnicity. Participants completed sexual lifestyle questionnaires and provided genitourinary samples at baseline and seven months. Participants were informed baseline samples would not be tested for seven months and advised to get screened independently. Colleges were randomly allocated 1:1 to intervention (TnT) or control (no TnT).

One and four months after recruitment participants at intervention colleges were texted invitations for on-site chlamydia/gonorrhoea tests. Students with infections were directed to a nurse health-adviser. A purposive sample of students who did and did not attend for screening were invited to qualitative interviews, subsequently thematically analysed (n=26).

TnT uptake was 13% (33/259) at one month and 10% (26/259) at four months. Of those tested, 5% (3/54) were positive for chlamydia and 2% (1/54) for gonorrhoea. Follow up at seven months was 62% (316/509) for questionnaires and 53% (265/509) for samples. Prevalence of chlamydia and gonorrhoea was 6.3% (31/503) and 0.6% (3/503) at baseline and 6.0% (16/265) and 1.1% (3/265) at 7 months. Interviews suggested low uptake of TnT was associated with little knowledge of STIs, not feeling at risk, and perceptions of stigma. Despite high rates of chlamydia and gonorrhoea at baseline and follow-up, uptake of college-based TnT by ethnically diverse teenagers was low suggesting this form of TnT may not be feasible. England urgently needs compulsory sex and relationships education, including normalising STI testing.
57. The use of a Multi-source feedback (MSF) tools in a longitudinal simulated General Practice surgery.

Dr Russell Hearn, Dr Liza Kirtchuk.

High quality feedback is key to informing reflection and professional development in medical education. MSFs have been found to be useful in postgraduate training but are not common place for undergraduates. We chose a simulated surgery as a safe place for students to develop both their giving of feedback and insight through feedback from patients, actors and GP tutors. We wished to explore junior medical students’ experience of using a multi-source feedback tool during a simulated General Practice surgery.

Students were enrolled on a first come first serve basis and asked to complete a MSF tool for each individual in their group. Patients and tutors were invited to complete the same tool. The MSF tool was developed to reflect similar tools used in postgraduate training and to be relatively brief, easy to use, and to allow professionalism concerns to be flagged up. A one-to-one discussion of the feedback was conducted by a GP tutor. Students were invited to attend an externally facilitated focus group to discuss the usefulness and challenges of the tool. Focus groups and MSF forms were transcribed verbatim and anonymised. The data was coded by one researcher, and then sense checked by the co-researcher followed by full thematic analysis. Students valued the use of the tool, in particular contemporaneous written feedback allowing them to use it as a tool for reflection. The activity allowed for them to develop skills in giving honest and open feedback.

Initial results suggest that wider use of an MSF tool in undergraduate GP teaching promotes meaningful reflection; is considered acceptable to students; and encourages professional development. Of key importance it that this is used in a safe environment to allow honest feedback. Our presentation will include key tips for incorporating MSFs to undergraduate GP programmes.
58. Using the electronic health record to build a culture of practice safety: evaluating the implementation of trigger tools in one general practice.

Dr Tom Margham, Dr Sally Hull

Identifying patients at risk of harm in general practice is challenging for busy clinicians.

In UK primary care trigger tools and case-note reviews are mainly used to identify rates of harm in sample populations.

This study explores how adaptations to existing trigger tool methodology can identify patient safety events, and engage clinicians in ongoing reflective work around safety.

The study was set in a single east London training practice.

The project team developed and tested five trigger searches, supported by excel worksheets to guide the case review process. Project evaluation included summary statistics of completed worksheets and a qualitative review focused on ease of use, barriers to implementation and perception of value to clinicians.

Trigger searches identified 204 patients for GP review. Overall 117 (57%) of cases were reviewed, and 53% of these had patient safety events identified. These were usually incidents of omission, including failure to monitor or review.

Key themes from interviews with practice members included:

“GP’s work is generally reactive, and they welcomed an approach which identified patients under the radar of safety. Its value lies in finding hidden risks and identifying errors before they happen” (GP)

All GPs expressed concern that the tool might identify too many patients at risk of harm, placing further demands on GP time.

Heart said “good idea”. Head said “hope it doesn’t significantly increase my workload” (GP)

Electronic trigger tools can identify patients for review in domains of clinical risk for primary care. The high yield of safety events engaged clinicians, and provided validation of the need for routine safety checks.

Lowri Davies, Beth Agnew.

Sexual assault and harassment is a significant issue for higher education institutions. In 2017, a Freshers' workshop was co-developed by staff and student group, to be delivered to all 'Freshers' in the Autumn of 2017. The aims of the workshop were to provide an evidence based learning resource for new full-time SGU students, on induction, around the issue of sexual consent and bystander action, including the role of the university and routes of reporting offences. The workshop was delivered by trained peer tutors, and would explicitly link the issues of sexual consent and bystander action to the professional responsibilities and identity of healthcare students at SGUL.

The evaluation of the workshop aimed to review:
   I. the quality of the workshop delivery by peer tutors;
   II. the effectiveness of the workshop to increase the knowledge and skills of Freshers around the issue of sexual consent and personal responsibility to act when witnessing harassment or assault.

The workshop was developed and delivered to Peer Tutors, who then were paid to deliver the workshops to 275 Freshers in the Autumn of 2017.

Freshers were asked to fill in a pre-workshop questionnaire, asking about anxiety, knowledge and skills relating to sexual consent and harassment. Participants were then asked to complete a post workshop questionnaire.

Data was entered into an Excel spreadsheet and the difference between before and after scores were calculated using a paired T test for each question.

The results of the 275 Freshers 'graduate' students who started at SGUL in August are presented. The full dataset may be available by January.

175 Freshers participated in 23 workshops in August 2017. Of 172 Freshers, 15% (26) had received similar training before. In all domains, students reported significant increases in confidence to 'very' confident in their: knowledge of the issues around sexual consent; knowledge of the definitions of assault and harassment; ability to intervene if witnessing harassment or assault; and ability to support students affected by assault. Qualitative feedback was uniformly positive: "Thank you for allowing me to participate in these consent sessions. Not only has it been very informative it has also helped me on a personal level. I feel more stronger than I have ever felt and feel I can get over what had happened to me in the past."

The Freshers' workshops were delivered to a high standard by the peer tutors, to a cohort of Freshers who mostly had no previous training. The peer tutor workshops were effective in improving the confidence of Freshers students to deal with any sexual harassment or assault they
60. GP Tutorials: Is there a Trainee- Trainer Mismatch?

Dr Puja Verma, Dr Tom Mtandabari, Dr Charlotte Lance

Health Education England stipulate one session of GP Registrars working week should be dedicated to face to face teaching/tutorial.

Currently there is no standardized format for a GP tutorial and no RCGP guidance for what should be covered.

Existing literature offers only limited evidence about what trainee’s value in a tutorial – we were interested to know how GP tutorial time was currently being spent by trainees on the Imperial Vocational Training Scheme and what trainees found valuable in a tutorial. We were also interested in what trainers felt should be covered in a tutorial.

Initially a focus group was carried out of 8 trainees. Using a semi-structured interview schedule we gathered data about the key tutorial topics that were being covered.

Questionnaire: All Specialty trainees on the Imperial GP Trainee Scheme were asked to rate how important a series of tutorials topics were on a scale of 1-10. We also questioned them about specific examples of good tutorials they had encountered.

All trainers on the scheme) were also questioned and ask to rate how important a series of tutorials topics were on a scale of 1-10. They were also asked to give examples of tutorials they found successful.

Understanding what GP trainees value in a tutorial compared to their trainers is invaluable for assuring the trainees needs are met. This information may also be useful in the training of local GP trainers.
61. How does generalist teaching in general practice shape medical students’ attitudes towards becoming a GP compared to specialist teaching in general practice?

Alice Meredith, Sophie Park.

The research is based on previous research (Chellappah and Garnham, 2014; Howe and Ives, 2001), which has shown that student experiences in general practice highly influence their considering becoming a GP. However, no papers with this conclusion determined what type of general practice experience in medical school they were referring to.

The aim of this study was to see if two types of general practice placements, those teaching specialties and those teaching generalism, affect students’ attitudes towards becoming a General Practitioner (GP). This was explored using a mixed method approach, starting with two focus groups of 14 students from UCL medical school years 4 and 5, which shaped the content of a questionnaire. The questionnaire was then answered by 60 UCL medical students in clinical years.

The study has found that students that have experienced generalist and specialty type teaching in the general practice setting, compared to only specialist placements, are more likely to consider a career as a GP. The results show that this may be to do with generalist teaching placements providing contact with a higher number of patients, teaching new knowledge not gained elsewhere in medical school, teaching more about a broader variety of aspects within medicine, being tied in with exam content and using a variety of different teaching methods.

More research should be carried out on a higher number of participants and potentially on students from different medical schools, in order to account for confounding variables and make these results more generalisable. If the same results are found elsewhere, perhaps GP placements teaching specialties should apply these findings in order to encourage more students to consider a career path in general practice. Additionally, perhaps general practice placements teaching generalism should be introduced in UCL medical school as early as specialty practice placements in general practice are.
62. Using a simulated disaster scenario to teach leadership to undergraduate medical students

Dr Ali Dhankot

The GMC requires students to achieve competence in leadership as outlined in the Medical Leadership Competency Framework (MLCF). A previous study at Imperial identified where leadership is taught in the MBBS course and found that there was a need to develop teaching around the domains of managing and improving services and setting direction. As a result, a simulated disaster scenario was created where participants have to take into account range of conflicting factors and weigh the evidence given to them to make appropriate decisions.

A discussion about experience in teaching leadership in an undergraduate setting and use this as a platform to debate methods of teaching leadership to undergraduates with reference to the MLCF and demonstrate how we have devised an interactive practical session to develop these skills.
63. Implementing health psychology through behaviour change training among pharmacy staff to improve NHS Stop smoking services

Sandra Jumbe

To share evidence of behaviour change interventions from a health psychology perspective and review its relevance to health research settings. Focusing on smoking cessation, the workshop will inform audience on how behaviour change techniques have been conceptualised into a practical training intervention for pharmacy staff to improve their delivery of smoking cessation support through the STOP Trial.

The Smoking Treatment Optimisation Programme (STOP) Trial aims to address low smoker uptake by training pharmacy staff to provide effective services as part of a cluster randomised trial. Smokers are four times more likely to quit if they use NHS Stop Smoking Services (SSS). Part of this service is delivered in local community pharmacies settings, where pharmacy staff are trained to provide smoking cessation support to smokers. Unfortunately, pharmacy based SSS have recently gone through mass decommissioning due to low smoker uptake. One potential reason for this low uptake identified has been the low numbers of staff actually trained to provide smoking cessation support within commissioned pharmacies. As such, the STOP Trial has developed a training intervention based on behavioural theory which compliments the national training pharmacy staff receive. The training focuses on initial smoker engagement from the counter and basic motivation interviewing skills when communicating to assessment smokers’ readiness to quit.
64. Is there a place for goal setting in general practice? Challenges for doctors and patients emerging from analysis of consultations in the GoalPlan Study.

*Professor Nicholas Steel, Alice Shiner*

To consider

1. Whether goal setting may have more benefit for some groups of patients (e.g., high risk of hospital admission or nearing end of life) and some practitioners (e.g., GPs or nurse practitioners) than others
2. What preparation and training is needed for patients and practitioners to benefit from goal setting
3. How the potential harms and benefits of goal setting can best be researched and what the key future research questions are

The GoalPlan study assesses GPs using goal setting during care planning discussions with patients at high risk of hospital admission, in order to identify patient priorities and set specific related goals to be met by a defined time. Following a brief introduction to GoalPlan participants will be asked to work in pairs, considering the meaning “goal setting” and what might be the challenges and benefits of using it in a care planning consultation.

To reflect on whether goal setting may have more benefit for some patients than others; the training implications; and how the potential harms and benefits should be studied, respectively.
W3 Practical hints and tips in improving chances of successful grant applications

Ms Fiona Reid

To provide very practical advice around what NIHR panels are looking for in a grant application. Outcome: Attendees will be encouraged and enabled to submit better quality grant applications with a higher chance of success.

The workshop will alternate between a) brief summaries of what panels are looking for in different aspects of grant applications as well as some of the common pitfalls, and b) small group discussions among participants of how these hints and tips could be applied in their own research areas.

**Intended audience** Researchers who have previously sought research funding or are intending to in the future; ideally will have research idea examples which they are happy to discuss within a small group
W4. Seeing through the eyes of learners: narrative research in medical education

Dr Kathleen Leedham-Green

The stories that people tell can have a profound impact on our way of thinking, and can illuminate the underlying causes of excellent or suboptimal practice in a way that is distinct from other forms of educational research. Narrative analysis as a research methodology is however relatively uncommon, and is fraught with arguments about reliability and validity. Our aim is for participants to discuss and experience the strengths and weaknesses of narrative research in medical education, and to be introduced to some of the core research considerations. By the end of the workshop, participants will have developed a plan for how they could generate, curate and present narratives in their own professional practice.

**Intended audience** This workshop is aimed at qualitative researchers, educationalists, and clinical teachers. Participants will be introduced to current discourses surrounding narrative research in a short presentation, followed by an exercise where we try to construct purposeful educational knowledge from a set of student narratives on consultations with obese patients in primary care.
W5. Data Sharing “Why When and How”

Ms Sally Kerry

The purpose of this workshop is to develop an understanding of the issues involved in data sharing and some practical steps that can be taken to facilitate data sharing.

Many research studies in primary care are funded using public money and consequently there is an obligation to make full use of the data not only by the original researchers but more widely. For example in individual patient data meta-analysis, individual level data from a number of studies are combined and analysed, usually by transferring data between institutions.

In addition journals may request individual level data to be made available in order to reproduce study results for verification. Finally data maybe requested under freedom of information requests; recently Queen Mary University of London was obliged to share data from the PACE trial of interventions to manage chronic fatigue syndrome with a patient representing a pressure group who were unhappy about the published conclusions of the trial.

Such requests may be outside the original consent conditions and many researchers are unsure about how to respond and what data can be shared while still complying with the Data Protection Act. Researchers may also want to retain sole access to data that they have not had time to analyse.

This workshop will focus on sharing data collected directly by researchers, rather than access to data held by NHS Digital.

Sally Kerry is chair of the Data Sharing Committee at the Pragmatic Clinical Trials Unit and a member of the Participant Data Sharing Group of the UKCRC Registered Clinical Trials Units. Chris Newby is a statistician who has experience of statistical methods for data sharing where data cannot leave its hosts server and is also a member of the International Primary Care Respiratory Group sub-committee.

**Intended audience:** The workshop should appeal to a wide range of researchers, from novice researchers to Principle Investigators of large studies.
W6. Undergraduate Longitudinal Placements in Primary Care: A case study. What works and what needs to improve.

Dr Liza Kirtchuk

The UK is experiencing a shift in healthcare provision towards primary and community care settings to meet the challenges of an increasing and ageing population, with more chronic co-morbidity [1, 2].

Concurrently General Practice (GP) recruitment is in crisis [1, 2] and there are concerns regarding the attrition rate of the current workforce [3]. Optimal exposure during undergraduate years is believed to enhance the likelihood of GP as a career destination [3] and strong recommendations have been made that GP should be promoted more vigorously in medical schools, through a greater exposure to the speciality and positive role models [4]. Traditional short block placements in undergraduate medicine, with their emphasis on acute episodes of care/illness, align poorly with this trend towards holistic community care. Longitudinal placements, which can be defined as "regular, recurrent placement(s) in the same setting with the same preceptor" [5], have been shown to tackle some of these challenges through the continuous relationship students develop with their patients, peers, tutors and the practice [5].

The GKT Stage 2 GP longitudinal placement aims to increase exposure to GP in the early years, with the benefits of longitudinal delivery. The programme commenced in September 2017, with all 400 2nd year medical students at King’s College London spending a day a week in GP, covering a total of 30 days.

With any new programme of this magnitude it is vital to explore the impact, feasibility and sustainability for all stakeholders i.e. GP tutors, students, patients and faculty. We will outline our programme and present our research strategy.


Intended audience: Healthcare professionals and administrators with experience of, or interest in promoting longitudinal placements and/or GP as a career within medical schools.